MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.
Thursday, October 29, 1998

The meeting in the above-entitled matter convened, pursuant to notice at 10:10 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair

P. WILLIAM CURRERI, M.D.

ANNE JACKSON

SPENCER JOHNSON

PETER KEMPER, Ph.D.

JUDITH LAVE, Ph.D.

DONALD THEODORE LEWERS, M.D.

HUGH W. LONG, Ph.D.

WILLIAM A. MacBAIN

JANET G. NEWPORT

ALICE ROSENBLATT

GERALD M. SHEA

C O N T E N T S

P R O C E E D I N G S

DR. WILENSKY: We are ready to begin our morning session. Welcome to everyone. Since we have met last the Congress has gone out of session. There are some changes that we've commented have occurred, both in terms of the size of the Commission will be increasing from 15 to 17 as of our next round, May, appointments.

Other aspects of the Commission's composition are going to remain the same, in terms of the mix of the representatives of the provider and non-provider community. Some additional language or interpretation may be provided about precisely what characteristics constitute whether an individual is in the provider or the non-provider category.

There were also some changes that occurred with regard to home health care, when we get to that portion of the discussion they will be referenced as appropriate.

We're going to start the morning session, however, with a discussion about hospital outpatient payments. This is particularly relevant and timely because of the proposed rule which has been issued with regard to hospital outpatient PPS. Jim?

DR. MATHEWS: Thanks. The Balanced Budget Act of 1997 directed HCFA to replace the current payment system for hospital outpatient services which is one of the last largely cost-based sectors of the Medicare program with a prospective payment system, or PPS, under which payments are fixed at a pre-determined rate. The BBA's mandates represent the most significant restructuring of Medicare's hospital outpatient benefit since its inception.

There are four main goals of this restructuring, to show the growth of Medicare payments for hospital outpatient services; to make payments more predictable for both Medicare and providers; to eliminate a flaw in certain payment formulas that results in an overpayment to

hospitals; and to reduce the beneficiary coinsurance that applies to hospital outpatient services. We've talked about these subjects before at a conceptual level. Last month HCFA published its notice of proposed rulemaking, how it plans to achieve these goals, so we now have the chance to address them in practice.

My presentation this morning is summarize HCFA's proposal, identify certain potentially problematic elements of the proposed system, and attempt to square these elements with your previous views on the subject in the form of a draft comment level that you received in your mailing materials.

I was asked to keep this presentation short, somewhat naively. It's not going to be short. But i did consider putting up the next slide which has a quote from one of the local professional associations and just asking if anyone had any questions and leave it at that. But I don't think the proposal is all that bad.

In the interest of brevity, however, I will skip over the historical background and instead go right to the proposal.

Under HCFA's NPRM, the prior link between costs or charges and payments will be severed. Instead, a fixed payment will be made for a given service, regardless of the costs incurred in providing it. As with all prospective systems, the outpatient PPS consists of several interrelated components that require definition: the unit of payment, classification system, the level of payment including any adjustments, and a means of controlling service volume.

The transition from the current system is complicated however, by a factor unique to Medicare's hospital outpatient benefit. This factor relates to how beneficiaries' coinsurance is calculated for these services. Historically, beneficiaries have paid coinsurance based on hospital's charges while program payments were based on the lesser of costs or charges net of coinsurance.

As hospital charges have grown more rapidly than costs over time, coinsurance payments have come to make up an increasingly large share of the total payment to hospitals. The BBA begins to reduce this disproportionate liability, but the means by which it does so complicates the new system, as I'll show shortly.

For a given service HCFA defines the unit of payment, that is the bundle of services that the payment is intended to cover, to include related ancillary items and services such as supplies, pharmaceuticals and anesthesia, operating room and recovery room charges where applicable, and so forth, that are integral to the service, provided at the same time and in the same place. Defining the unit of payment in this way creates a package of services corresponding to a tightly defined outpatient encounter.

The definition of the unit of payment is consistent with MedPAC's previous recommendation on the subject. However, I believe HCFA's longer term goal is to expand the size of the payment unit. The agency doubts that the proposed level of packaging will sufficiently control increases in service volume that are attributable to ancillary services. This is why HCFA has chosen a fairly robust system to classify services under the outpatient PPS, the ambulatory payment classification system, or APCs.

APCs classify the full range of ambulatory services, except those covered by separate fee schedules, into groups based on clinical similarities of costs. The APC system uses two different approaches to classification, depending on the nature of the service. Some services, such as surgeries, x-rays, EKGs and other diagnostic tests are classified on the basis of their corresponding codes under the HCFA common procedure coding system or HCPCS. The APC classification of surgical procedures proposed for hospitals is the same as has been proposed for ASCs, although the relative weights and the payment amounts differ.

The classification logic for medical visits differs, in that it partially relies on the international classification of diseases or ICD-9 diagnosis code to categorize services. HCFA chose this approach because it more accurately captures the increased differentiation in hospital costs that occurs under expanded packaging scenarios. These two methods together classify all services into APC groups for both rate setting and payment.

The question of grouping has been one of the most persistent sticking points throughout HCFA's outpatient PPS development. The fundamental question is if you're just pricing services, why is it necessary to implement such a complicated classification system? For example, HCFA has a certain amount of success with line item pricing under the Medicare fee schedule for physician services. At the same time, HCFA has also successfully grouped services provided during inpatient admissions using DRGs. The nature of the services provided in the outpatient setting lies somewhere between inpatient services and those routinely provided in offices, so the decision here can go either way.

There are certain benefits to grouping. HCFA argues that grouping helps prevent upcoding, facilitates payment rates for new services, and low volume services, and is consistent with the system that's been proposed for ASCs. Additionally, as I noted a moment ago, grouping allows the definition of an expanded unit of payment which is a pivotal element of this proposal. HCFA believes that in order to achieve real volume control under the outpatient PPS an expanded unit of payment is necessary to constrain the growth of ancillary services.

Enhanced bundling would mitigate the need for an extended volume control mechanism somewhat in much the same way that a means of controlling volume in the inpatient setting is implicitly built into DRGs.

DR. LAVE: Jim, can I stop you there? This is where I got confused in reading what was happening. Let me try and explain and maybe you can help me. Maybe nobody else had this problem. I can understand what's going on with the surgical procedure, a D&C or whatever it is. You have a bunch of things and their together and they become a visit.

So they seem to me, to be, somewhat clear. But I have no idea what's happening on the visit side. If I go for an x-ray, and that's all that I'm going for, is that a visit or is that not a visit? And how is that handled?

I'm trying to figure out what these visit things really are in the outpatient side, that are being grouped together and what gets bundled underneath it, and I can't figure it out.

DR. MATHEWS: Sure. Initially I had an overhead or handout that displayed what goes into each type of service. But there was a decision made that it would be a useless slide to present.

But anyway, the x-rays are more analogous to the surgical procedures, in terms of how they're defined under the APC system and what gets packaged with them. So to take your example, you walk into the hospital to get an x-ray. It's a referred service from a physician's office who doesn't have the machine in the office.

You walk in the door, there's an exam table maybe, there's a gown that you put on, there's a technician operating the machine, there's film, electrical power, that kind of thing. The costs of all of those services would be considered part of the package or the bundle of services that the unit of payment reflects here.

In the case of medical visits --

DR. LAVE: Now could I just follow up on that? I don't know if anybody else has this same problem? If I go to a doctor's office and I have an x-ray, would the same things be

included in the technical component of the x-ray? I'm just trying to figure out now the difference between -- would the same stuff all be bundled up? It sort of is a way you would traditionally think an x-ray ought to be paid for.

DR. MATHEWS: This is the question. This gets right to the heart of what you mean by comparability of payment across settings.

DR. LAVE: I'm not talking about payment now. I'm talking about what goes into --

DR. MATHEWS: But that's part of how you define what you're going to pay, is based on the unit that you're paying for. If you define it the same way across all of these settings, that would inject a certain amount of rationality to the system.

DR. WILENSKY: How is it different from -- I don't know, you may want to maybe continue through this. But if, rather than maybe compared to what would go on in an office setting, is what is being contemplated in your example different from what would have occurred under the current outpatient charge basis?

DR. MATHEWS: Under the current system, when a hospital submits a claim for any of these kind of services, they do so using --

DR. WILENSKY: Are they line item?

DR. MATHEWS: They are line items. So you'll have some services, major services such as surgeries or x-rays or diagnostic tests, that are identified by a HCPCS code, but you'll also have separate line items that each have a charge associated with them for medical surgical supplies, anesthesia, pharmacy charges, recovery room charges, things like that, that appear as a separate line item on your bill.

DR. LAVE: I can really understand the surgery side because I can understand what the surgery is. It's these other things that I really don't understand how they get grouped

together, like an x-ray or all these other things. I mean, if it's a visit, what is a visit and what's included in a visit that wouldn't have gotten included before? What are the units of payment? I'm really struggling to understand what's going on here.

DR. MATHEWS: HCFA actually explicitly defined for each category of service here the particular items that would be included in the unit of payment. Under the surgeries they include things like anesthesia. So anytime a surgical procedure is billed the cost --

DR. LAVE: Now get off of surgery. I understand surgery, it's everything else I don't understand.

DR. MATHEWS: Okay, we'll start with everything else, then.

DR. LAVE: There are two things I don't understand. One thing is that the way that they're thinking about, and comparable to the way that it would be paid in the doctor's office -- I mean, if a doctor gives an x-ray, do they charge for all of the component parts or do you get a bill for -- if I go to a hospital and I only have an x-ray, do I only get a bill for an x-ray? Or do I get a bill for a thousand other things?

DR. MATHEWS: It is a possible that you will get a bill for all of these other line items.

DR. CURRERI: I had one thing that bothered me. I assumed that the ICD-9 diagnoses were put in there to try to gain some idea about the frailty or the severity of illness or something of that sort. And I look at that as probably a proxy for the time spent, if I'm right about what I'm reading.

MR. SHEA: A proxy for what, Bill?

DR. CURRERI: A proxy for the time required, that the sicker the patient, the more diseases, the more time and intensity of the visit.

But what do you do when you have five ICD-9? Is it like you just take the top one, like it is with the DRGs? Or do you combine? What do they do when there are five or six?

DR. MATHEWS: It's not explicitly spelled out in the proposal. If I recall how the claims processing works, though, there is a field for the primary diagnosis that is the reason for the visit. The are fields for secondary diagnoses are not given as high a priority on the claim. So I would believe that it's the primary diagnosis that would be used in this matrix. But again, it's not explicitly spelled --

DR. CURRERI: But doesn't that open up a lot of room for gaming?

DR. MATHEWS: Yes, it does.

DR. CURRERI: Because you just put the worst ICD-9 at the top as the primary?

DR. MATHEWS: Yes.

DR. WILENSKY: Jim, would it be possible to distribute later today or tomorrow what you were thinking about showing earlier, that would show for these groupings what would be included under them, so that for the medical visits -- which may include procedures and may include clinical lab -- you'd have some idea about what was being grouped into medical coded visits?

DR. MATHEWS: Sure.

DR. WILENSKY: I think it will just make it clearer for several of us. I assume it's things like clinical lab and other explicit components of what can go on in a medical visit? I don't know whether there are other --

DR. MATHEWS: Lab is not yet there. It's not yet going to be included here, but it's something that could be a future plan. I'll address those issues here.

DR. CURRERI: Can I just ask one further question? Has there been any analysis done to see whether the ICD-9 component of this actually does relate to severity or intensity of the visit or anything? I mean, I know PPRC did a fairly extensive analysis and related time was more -- the longer the time period, the less intensity the visit got, and so forth.

It seems to me they're throwing in something here that, to me, makes no sense.

DR. MATHEWS: There is a reason for what HCFA has proposed here. When they were developing the system, they did model classifying medical visits using just the HCPCS coded service which has time built into it, time and intensity. And they also modeled the payment structure using ICD-9 diagnosis. When they did just the HCPCS, the differentiation between the lowest intensity service and the highest was about four-and-a-half times. The highest one was four-and-a-half times greater than the lowest.

When they used ICD-9 diagnosis code, the differential was about a factor of 14. The highest code

was 14 times greater than the lowest. When they do the matrix approach that they've done here, the span is about an order of 10. The highest was 10 times greater than the lowest.

The reason that they've done this, though, is because if you just looked at the HCPCS codes for the medical visits -- 99201, 202, 203 -- you don't get much differentiation in costs just using HCPCS. When you add the diagnosis code, under the current level of packaging, the cost differentiation expands a little bit. Things become clearer, why one is distinct from another. If you enhance the package of services provided in the context of medical visit for a given diagnosis, that is where the real differentiation in prices occurs.

So suppose you have a simple E&M visit for rule out pneumonia. Under a very simple level of packaging, those costs are not all that different from the same coded visit for

another diagnosis. However, if you expand the bundle of services associated with rule out pneumonia, including things like clinical lab, chest x-ray, that kind of thing, then you start seeing differences by diagnosis. And that's part of the reason that HCFA has decided to key on diagnosis for these services. It does not have the importance now that it would in the future.

DR. LAVE: Could I follow up on that example? That is it makes a difference why I go for a visit because if I just go for an x-ray, then the x-ray is billed separately?

DR. MATHEWS: That's correct.

DR. LAVE: But if I go for a medical visit that includes an x-ray, then that's included in the bundle of services?

DR. MATHEWS: It could be included.

DR. LAVE: I'm trying to figure, I mean clearly something big has to be included in the bundle of services at a 14-to-one spread of cost. So the difference has to be what you're sweeping up under the bundle.

Now it would seem to me that if I could go for a separate visit and have an x-ray and get paid for, or have a bundle, it strikes me that you're encouraging two visits, at least off the top of my head, if I can bill for that separately. Have I got this wrong? Or could I only get an x-ray if it's part of a visit? This is why I'm confused.

DR. MATHEWS: Under the current system, the visit and the x-ray, if the hospital provides both, would be paid separately.

DR. LAVE: I guess then we're back to what are the services that get swept up under these different visit counts that are being costed so that if I have cancer and a long evaluation and management, what are the services that are being costed that would originally be billed for separately that are now included in the bundle, that don't include clinical labs because that's

separate, that don't include x-rays because that's separate, and that don't include certain procedures because that's separate? That's why I'm confused.

DR. MATHEWS: I can get that list to you.

DR. WILENSKY: I think at this point we'll accept that there are substantial variations and we'll get the listing?

DR. KEMPER: But just can I ask one question that I'm a little confused about? When you say could be included, that could be included, do you mean it could be for some procedures or some visits but not others? Or do you mean it could be included by HCFA in a future system?

DR. MATHEWS: The latter.

DR. KEMPER: But right now it's not?

DR. MATHEWS: Right now it's not. But part of the reason HCFA has set up the system this way is to allow for that possibility in the future.

DR. LAVE: Sorry.

DR. MATHEWS: Can we go to the next slide? In conclusion...

[Laughter.]

DR. MATHEWS: There are also drawbacks to grouping in the outpatient setting. First, grouping deviates somewhat from the principle of consistency of payment across ambulatory settings. As HCFA observes, a consistent unit of payment is necessary to develop unified ambulatory care payment structure. The unit of payment that HCFA proposes now, in the NPRM, is consistent with that already used in the ambulatory surgical setting and is close to that governing Medicare payment for services provided in physician's offices. The expanded payment unit that grouping allows would be anomalous compared with these other settings.

Expanding the unit of payment, which was the major objective of groupings, raises a second problem, accurately capturing the package of services across settings and over time. It is true that greater numbers of ancillary services per visit account for some of the growth of Medicare outpatient spending and that increased bundling of these ancillaries would provide an incentive to reduce this growth.

However, not all of the ancillaries related to a major service or visit are provided in the hospital. For example, pre-operative lab work is most often provided in a physician's office or through an independent clinical laboratory. A variety of ambulatory settings could come into play in providing an enhanced bundle or package of services, raising such questions as who serves as the coordinator of services and who receives the payment. Determining the relatedness of ancillary services provided in the treatment for concurrent but independent health conditions may also be different.

Not only would an expanded bundle of services have to come to grips with the question of place, but also the question of time. HCFA would have to determine a window around a major service or procedure within which all ancillary services billed from any source would be subject to a determination of whether they would be considered part of the package.

In other words, expanding the unit of payment to include a broad array of packaged ancillary services would require developing a full set of ambulatory care episodes.

There are also equity questions that come into play here. Previously you've indicated that, as a matter of principle, Medicare's payment should reflect the costs of providing services according to the needs of the patient receiving them. Grouping services has the potential to distort this principle in that payment reflects not only the cost of a particular service, but also the cost of all services that are in the group with it.

HCFA would also have to develop the administrative capacity to expand the payment unit to the level that grouping permits. Computer systems would have to be developed to unify claims processing across fiscal intermediaries and carriers, keying on data that heretofore has not been a factor in ambulatory care reimbursement, such as the diagnosis code.

Given the advantages and disadvantages of using groups to price and pay for outpatient services, there are several options you could consider. You could endorse this aspect of the proposal. You could recommend that HCFA not group these services but rather take a more elemental approach. Or you could remain silent on the issue all together. However, it is a major policy issue that you might like to discuss.

The next step in HCFA's proposal is rate setting. Rate setting involves calculating relative weights for services and applying these weights, along with utilization estimates, to an aggregate budget amount. The BBA directed that the relative weights for services or groups of services under the outpatient PPS be calculated on the basis of their median costs to utilization in 1999.

HCFA modified this approach, believing that the utilization levels for individual services cannot be projected accurately as described by the BBA. The agency instead calculated a conversion factor using 1996 data, then trended it forward to 1999. HCFA estimated line item costs for a complete calendar year of hospital outpatient claims and aggregated the line items to the previously defined unit of payment.

The resulting unit costs were adjusted to account for differences in input prices attributable to local wages. Each claim was then matched to its respective APC group. Relative weights were calculated by dividing the median cost for each APC over the median cost of a mid-level clinic visit.

These weights, together with volume estimates, are applied to an aggregate budget target to calculate a dollar conversion factor. The budget target consists of two components, program payments and beneficiary coinsurance payments. The aggregate program payment is budget neutral in the base year, except for a mandated reduction in payments due to the elimination of something called formula-driven overpayment or FDO.

We've talked about FDO before. While its elimination was effective in fiscal year 1998, it's effects will be felt under the outpatient PPS. Total program payments under the new PPS would be equal to what they would have been under prior law, less the formula driven overpayment.

Beneficiary coinsurance for each group is calculated as 20 percent of the median charge for the services or procedures that compose the group. Because median charges are generally less than mean charges in the outpatient setting, this provision reduces coinsurance payments relative to prior law. The conversion factor was calculated by dividing the aggregate budget amount by the sums of the relative weights for all services under the outpatient PPS. The conversion factor would be $46.32

in 1996 and $50.67 in 1999.

The base payment rate is simply the product of the relative weight and the conversion factor. The rate is divided between the program payment and the beneficiary coinsurance payment. The BBA directed HCFA to manipulate these shares to reduce the disproportionate beneficiary coinsurance liability over time. I'll get back to that in a minute.

The only proposed adjustment to the outpatient PPS rates is a wage index adjustment. HCFA proposes no adjustments or special treatment for cancer hospitals, sole community hospitals, Medicare-dependent hospitals, teaching hospitals, or those hospitals that a

treat a disproportionate share of low income patients, all of which receive such treatment under the inpatient PPS.

Outlier payments will not be made under the outpatient system. HCFA proposes to discount the payment for second and additional surgical procedures by 50 percent under the new system, paralleling the methodology current governing ASC payment.

Finally, HCFA proposes to discount payments for certain surgical procedures that are not completed.

The conversion factor is updated according to a schedule specified in the BBA. This factor is the hospital inpatient market basket less one percentage point for each year through 2002. The APC system will be recalibrated at five year intervals. Otherwise, revisions to the composition of the APC groups are expected only to follow annual revisions to the HCPCS and ICD-9 coding systems. New codes will be assigned to existing APC groups on a two year provisional basis until a determination can be made whether or not the service warrants the creation of a new APC group.

HCFA proposes initially to use an expenditure cap to control the growth of service volume, which is consistent with your March report recommendation on this subject. Under an expenditure cap mechanism, if utilization in a given year results in aggregate expenditures that exceed a predetermined budget target, the conversion factor for the next year will be adjusted downward, resulting in lower payment rates for each service.

HCFA believes that this method will not be reliable due to the instability of assumptions regarding service utilization beyond calendar year 2001. As I mentioned earlier, HCFA states that much of the growth in outpatient spending is attributable to increased provision of

ancillaries and that enhanced packaging would help curtail this growth. Consequently, HCFA is soliciting longer term approaches to controlling the growth of outpatient service volume.

Once the outpatient provisions are fully operational, it will likely result in substantial reductions in aggregate Medicare payments for hospital outpatient services and significant redistributions of payments among hospitals. These are attributable primarily to three elements of the BBA's provisions, reductions in payments due to the way beneficiary coinsurance is calculated, redistributions of payments resulting from the mechanics of the outpatient PPS, and reductions in payments attributable to the FDO elimination.

On the coinsurance issue, HCFA's estimated 3.8 percent aggregate payment reduction at the outset of the outpatient PPS stems from the way beneficiary coinsurance is calculated, using the median charge rather than the mean to determine payment amount. Additionally, part of the redistribution of payments is related to how the new system works. Some redistribution in payments would occur in transitioning to any form of PPS. Even in going to a service level fee schedule there would be winners and losers stemming from the relationship of individuals, hospitals, costs, charge and payment structure to payments based on the mean or median of that for all hospitals.

However, some payment redistribution is attributable to the APC method HCFA uses to classify and price services. If the services that compose the groups are not homogenous in terms of resource use, the resulting payment may be statistically appropriate for the group as a whole, but is not appropriate for some or all of the services that provide it.

Further, if the provision of these services within groups is unevenly distributed among classes of hospitals, hospitals will be disproportionately affected due to a technical artifact of the payment system. We have more detailed data on the variation of costs for selected

procedures, both by hospital group and by APC, in tables one through four of the handouts you received this morning.

In the example I have on the slide here, you can see that for these six HCPCS codes that compose this APC there is, at the outset, a significant variation in the relationships of the median service costs for the code compared to that for the APC group as a whole. And the same could be said for the relationships between the service level payments and the APC payment.

DR. LAVE: Can you explain this a little more? Now there will be one payment for all of this now?

DR. MATHEWS: That's correct. What happens is that the historical relationships between payments and costs at the service level will change, because now the costs or the payment is the same for all services that compose the group.

Finally, a large payment reduction will result from the elimination of the formula driven overpayment that applies to the blends. HCFA's outpatient PPS proposal does not show these impacts, only those impacts attributable to the PPS implementation. We estimate that eliminating the FDO results in a payment reduction of about 16 percent for blended services, which translates into an aggregate reduction of about 9 percent in total payments to hospitals.

Overall, we estimate that aggregate Medicare payments will be about 80 cents for each dollar of reported costs when the outpatient PPS is implemented. Table five in your handout presents a more complete assessment of the combined effects of FDO and PPS.

In sum, the BBA's outpatient provisions do reduce Medicare spending for hospital outpatient services, both in current dollars and in future growth. However, the magnitude of these impacts, coupled with their disproportionate distribution among classes of hospitals, may affect hospital's ability to provide these services to beneficiaries. At the very least, such constrained

payments may hinder the continued migration of services from inpatient settings to less costly ambulatory settings.

Previously you've indicated that the aggregate level of payment should be sufficient to provide adequate and appropriate care to Medicare beneficiaries. You may want to consider the adequacy of this level of payment in responding to the HCFA NPRM.

Beyond the aggregate reductions, specific classes of hospitals experience much greater payment shifts. Payments to rehabilitation hospitals under PPS will fall by 24 percent compared with current rules. Cancer hospitals will see reductions of nearly 30 percent. And children's hospitals will face a 35 percent drop in payments solely attributed to the way the PPS works. In general, these hospitals rely on their outpatient units for a greater share of their Medicare revenues than most hospitals.

Two classes of hospitals, not necessarily mutually exclusive, experience particularly large reductions in payment relative to all hospitals under the new system. These are low volume hospitals and certain types of specialty facilities. With respect to low volume hospitals, our research confirms HCFA's proposition that these facilities incur higher per unit costs in providing outpatient services. As a result, these hospitals are affected most heavily by payment on the mean. The conditions that produce these higher costs are largely external and unlikely to change once the outpatient PPS is implemented.

The second class of hospitals that are likely to experience significant payment reductions consisting of a diverse variety of specialty facilities is somewhat more problematic. After consultations with representatives of the affected hospitals, we tend to believe that there are qualitative differences in the services provided under the same HCPCS code that are attributable to the characteristics of the patients these hospitals serve.

Given the distribution of impacts of the BBA's outpatient provisions, you may want to discuss whether or not HCFA could consider payment adjustments or other special treatment that would apply under the new system.

Finally, as if this system isn't complicated enough, there is the beneficiary coinsurance issue. For each APC, the initial coinsurance amount will be 20 percent of the median charge of the services that compose the group. As a result, the beneficiary coinsurance percentage is different for each APC. Further, at the outset of the new system, the coinsurance percentage for hospital outpatient services will still be greater than the 20 percent copay that applies to most other Medicare services. You'll see a few examples here.

The BBA does provide for a mechanism of reducing the beneficiary coinsurance liability. The dollar amount of the coinsurance is netted against the APC payment rate to calculate the program payment. After the first year, for as long as the coinsurance is greater than 20 percent of the payment rate, the coinsurance remains fixed at this dollar amount. As the payment rate is updated, the coinsurance represents a diminishing percentage of the total payment. This trajectory will continue independently for each APC until the copayment equals 20 percent of the rate, at which time it will increase with the rate updates.

We've previously estimated that it may take as long as 40 years to achieve the desired balance for all services.

Hospitals may elect to reduce beneficiary coinsurance immediately, but the reduced coinsurance cannot be less than 20 percent of the APC rate for the service. HCFA is following the mandate of the BBA in reducing beneficiary coinsurance. Reducing the coinsurance to 20 percent of the total payment to hospitals at a faster rate than that specified in the BBA would require action by Congress.

In addition to the points I've enumerated here, HCFA is also soliciting comments on a number of outstanding technical issues related to this proposal, and I've listed these in Attachment A of your mailing materials.

At this point, I'd like to stop and I'd be happy to answer any questions or facilitate your discussion.

DR. WILENSKY: I would like to make sure that the commissioners look at the last couple of pages of the handout that Ted Lewers has provided us. I think, as we discuss the kinds of differences or the impact, it's particularly instructive to notice that even with these reductions for at least some hospitals, that the differences that are shown here -- we can make available a copy so the public that wants to see this may, or Ted maybe you can alert how people can get a hold of this -- that there are significant differences in at least the examples, the CPT descriptors that are provided here, between the proposed physician practice expense, the ASC facility payment, and the hospital outpatient facility payment.

So we're really looking at differences. As we make your comments, just remember you're looking at differences on at least two dimensions relative to what had been paid or would have been paid under the old hospital outpatient and what appears to be for a comparable diagnosis, although maybe not comparable severity, extremely different payments, even with the proposed outpatient facility payment. Just to alert people that you really need to keep your thoughts on the variations in both directions.

DR. CURRERI: I paid a lot of attention to your Attachment A in the areas that HCFA had requested comment, and one of the things that I think that is bothering a lot of us is that we seem to be deviating from coming to some standardized payment system that goes across the board, to me it sounds like every little payment whether it's outpatients or nursing or home nursing

care or whatever, each one is getting its own little way of payment. So that rather than coming to some standardized payment form, we're getting a hybrid of all kinds of different things.

And related to the outpatients, it seems to me if I read your article right, essentially what they're doing is instituting a form of expenditure targets and then they're readjusting the updates each year for the short term, at least, based on what they expect the expenditure -- what their target was compared to actual expenditures. And in the long-term they want to go to the sustainable growth rate, which we now have for physicians.

And my question is why not go to the sustainable growth rate immediately, rather than instituting this short-term expenditure target which seems to add another new twist to another new program, which is different and is going to have to be changed in three years?

DR. MATHEWS: HCFA is actively soliciting comment on this because I believe they're not sure on what the best approach is going to be, in terms of the provider community, defined in terms of both hospitals and physicians. The concern about implementing the SGR on hospitals is that it makes hospitals liable for decisions over which they do not have 100 percent control, that it's basically the physician who's ordering the service.

So the physician orders a CAT scan for the patient, if that CAT scan causes that hospital to exceed a certain target, then it becomes liable for the service that it didn't order.

DR. WILENSKY: Can I just have you clarify? Is the distinction you're using is that the sustainable growth rate is basically a GDP calculation and the expenditure target can be whatever it can be, so it's looser? Is that the distinction you're making? Because it's obviously equally true under the expenditure cap that the physician is ordering the test. That is the nature of this beast.

DR. MATHEWS: Right. I'm not quite certain of the nuances between the two proposals. As HCFA has laid out their notion for how the SGR might be applied to hospital services, it does include a specific formula for inflation, for increased utilization, changes in medical technology, that sort of thing.

I don't know if the shorter term budget cap has such an explicit formula built into it.

DR. NEWHOUSE: When I was a kid I used to listen to the Lone Ranger and it always started out by saying, we take you back to the days of yesteryear.

[Laughter.]

DR. NEWHOUSE: I'd like to take you back to last March and remind us what we said in our report under unit of payment. We said to be consistent with the unit of payment used in other ambulatory care settings, the payment unit for the hospital outpatient PPS should be the individual service. Only those ancillary services and supplies integral to a service should be bundled with it for a single payment.

So we clearly had in mind what, in the post-acute context we've called the silo problem of these different systems that are potentially inconsistent with each other. And our thinking was that if you paid for the same service differently in different sites, you could get providers shifting sites to take advantage of the differential and you could potentially get them relabeling sites to take advantage of the differential. So whether you called the building next door to the hospital the medical office building or the outpatient department was a somewhat arbitrary decision that might reflect how it was reimbursed. So we wanted a similar payment.

Now we seem to be getting anything but that, so Jim, now I'd like to go to your slide that said benefits of grouping and drawbacks of grouping. Now it seems to me that more or less

the benefits and the drawbacks, as you lay them out, could apply in both the hospital outpatient department site and the office site; isn't that right?

DR. MATHEWS: That's correct.

DR. NEWHOUSE: So however we come out on whether things should be grouped or disaggregated, seems to me we should want consistency, which is where we were last March. So at least we're trying to be consistent.

It seemed to me the burden of proof would be on someone who said well, the benefits outweigh the drawbacks in one site but not in the other site, to go to this different service.

Now as sort of a side comment on that, am I right in inferring that -- well, let me start by saying that HCFA could have used, as you said, it could have used just the HCPCS visits and if it wanted to go to a more grouped system it could have grouped them into APCs also on the physician side presumably, the office side. And it introduced ICD-9 diagnoses into this as well to cross-classify. Now that begins to smack a little bit of the inpatient side.

So that's the third dimension on which there is neutrality because several of these patients could potentially be treated as inpatients, I assume, although somebody might have to rule on whether this was a medically necessary admission.

But I at least would -- however we come down on grouping or not grouping, and I personally tend to think the drawbacks probably outweigh the benefits but reasonable people could differ. I think it's harder to argue that you should have different systems, that you should either stay with a group system or stay with an ungrouped system across the board.

The second point is I'd like to go to your slide on costs toward the end or more generally. In terms of what is the cost of the service in this setting? I'd like to see if you agree with a couple of points.

First of all, it seems to me the incentives under the system we have been living under for the hospital have been to shift as many costs as you could to the outpatient side, because you had the outpatient reimbursement was essentially cost-based and the inpatient side was not. So anything you could put over on the outpatient side and say that was a cost you'd get paid for. So there was a clear incentive to do that.

So point one is kind of, to some degree -- and I guess I wonder to what degree -- the costs you're quoting here or citing will reflect a hospital's ability to classify overall costs over in the outpatient side; is that right?

DR. MATHEWS: I followed you up to that last --

DR. NEWHOUSE: The underlying issue is going to be to what degree are there kind of arbitrary definitional issues running around in what we're calling costs. So the first point is what get -- let's take, for example, the administrator's salary. The administrator, he or she presumably handles both the inpatient department and the outpatient department and there's presumably some allocation of that salary to the outpatient department.

DR. MATHEWS: That's correct.

DR. NEWHOUSE: And there will be accounting rules for how to do that. But presumably the hospital will seek, as best it can, to put as much of the salary over in the outpatient department. Had been, under the old system.

MR. MacBAIN: It won't matter now.

DR. NEWHOUSE: It won't matter now. But the point is, when we come to saying here's what we're paying and here's what the cost is, the cost that we're using will reflect presumably how these costs have been defined.

DR. MATHEWS: That's correct. I guess what you're getting at is it's always been a historical assumption here that after the implementation of the inpatient PPS hospitals shifted a lot more of their overhead accounting costs to these --

DR. NEWHOUSE: That's what I'm getting at. But hospitals could have done that to a greater or lesser degree, depending on how aggressive they were with this.

DR. MATHEWS: That's correct. In the waning days of ProPAC we did a very quick analysis, to the extent that the data permits, as to whether that has happened since the implementation of the inpatient PPS. And it doesn't show up very clearly that there has been a wholesale reallocation of overhead costs to the outpatient departments relative to the way they've been allocated historically to the inpatient settings, as well.

We can go back and revisit that.

DR. NEWHOUSE: No, I don't know that -- I'm not asking you to do that. I think that's kind of water over the dam. I'm getting to what is the cost that we should want to have in our heads when we're thinking about what we should pay.

So the second point, presumably if we think about the people going to the inpatient side, the outpatient department and the office, I think our presumption is that there is some degree of case mix difference between these groups. That for the same procedure the people that are getting hospitalized will be the people who are more at risk. And the people that are being done in the office are the least at risk. Is that fair?

So setting aside the incentive to shift people once you have a system in place that, for a given clinical distribution of people that makes sense across these sites, that there could well be some cost differentials here because of the varying case mix. Judy, do you want to comment on that?

DR. LAVE: No, I want to follow up on -- I think it's kind of related to your --

DR. NEWHOUSE: Then I want to keep going.

Where I come to, we don't know what the incremental cost is, but presumably that should be what we would want to pay. And a lot of the cost, it seems to me -- Phil, I have no idea how much -- are fixed or kind of quasi-fixed costs. Space costs, for example, in the outpatient department. When we say how those get allocated to services, that again is something that is essentially fixed if we do, so that -- and I think but I have no data that it could be that the marginal cost is quite a bit less than the average cost for a number of these things. So that built into this is kind of an incentive to do more.

So I guess my bottom line here, I'm a little bit nervous about using average accounting costs for thinking about payment, although the average costs have to be recovered in some fashion.

Let me stop with those two things, so let me summarize. I think the larger point is or what the Commission ought to focus on first is do we want to have similar systems for the same patient across sites? It seems that we said we did in March. And if so, what do we do next, given that general view? Which system then, if we want to be consistent?

And how do we want to think about how cost or average accounting cost, which is sort of what we seem to have at best, plays into what rates should be? We need to address those two issues, it seems to me, among others.

And actually, Ted's tables that Gail was calling attention to, dramatically make the point because there are huge differences between the practice expense on the office side, the ASC payment, and the OPD payment for many of these services.

DR. WILENSKY: Which may both reflect in difference in severity of the patient being treated and the reservation price of keeping hospital outpatient facilities around. But nonetheless, not necessarily costs we want to bear.

DR. NEWHOUSE: Or you may want to pay them in some different fashion. I'm not sure what that fashion would be, but to try to minimize the incentive to shift patients while, if you need more fixed costs in the OPD because you've got standby capacity, sicker patients, et cetera, that you would do that in some other fashion than simple payment per case.

DR. MATHEWS: I could also clarify that the three sets of numbers for the proposed revisions to these payment systems come from completely different sources. The numbers from the ASC system are the results of a survey that HCFA began on ASC costs in 1992. And I think they first started getting results back in 1994.

The hospital outpatient numbers are generated using cost report data and claims charge data. And I'm not sure what the current status of the where the physician practice expense numbers came from. But again, a completely compartmentalized source. There's no uniform way of accounting for costs across these settings. So that also accounts for some of the variation that we see in these tables.

MR. MacBAIN: Just first a question on the sustainable growth rate or expenditure targets before that. Do they apply to combined expenditures both in ambulatory surgical centers and hospital OPDs? Or are the hospitals treated as a separate silo?

DR. MATHEWS: HCFA has laid out a couple of different options. The current short-term proposal, as I understand it, applies only to the hospital settings but their options do include alternatives which would bring the ASCs into the system, as well, and another option which would, I believe although I'm not certain, apply to all ambulatory settings.

MR. MacBAIN: It sounds like we're heading down the road of having different constraints on spending for each of a number of different silos. We've got the medically inpatient update factor, we've got the home health expenditure caps, we've got ASCs, we've got hospital outpatient, we've got the sustainable growth rate for docs.

So we're looking at each of these silos and saying the rate of growth of each silo is going to be limited by its own set of calculations and meanwhile technology is moving the grain from one silo to another. We can create an awful lot of dislocation in the whole system by having these different constraints if the constraint is in the wrong place.

If it turns out that technology and practice patterns and preferences begin to move more and more things into the physician practices but the sustainable growth rate then penalizes physicians for doing more in a better place, while we're sitting over here with hospital outpatient departments operating well below their expenditure targets, it isn't going to work. The system is trying to freeze into place the existing technology of today.

In trying to move this along, is there a possibility of staff research into what would happen if we tried to use one similar Medicare sustainable growth rate factor?

DR. MATHEWS: We've talked about that at the staff level and have decided to defer to direction from the Commission as to whether or not we should pursue it.

DR. NEWHOUSE: I would have said we've got to back up one stage and see if we want separate silos before we talk about adjusting the silos.

DR. CURRERI: Yes. I just want to back up what Bill said. My biggest concern with all this thing is that a hospital account is going to become the most important figure in the whole thing to figure out which silo to put people into and that's a problem.

DR. ROSS: Just two quick thoughts on that. One, I think this is an appropriate topic for this afternoon when we do a more general discussion of rate setting and payment updates.

But the second, Bill what you're pointing out is you're objecting to sort of the automatic mechanisms, if you will, sustainable growth rate mechanism. In fact, we've historically had exactly this issue of separate rate setting. The difference has been do we have some kind of discretionary input, either Congressional or other, or do we put it on autopilot.

But the SGR isn't introducing a new silo, it's introducing a new way of updating one particular silo.

MR. MacBAIN: Yes. The problem of the silos gets worse when you have differential constraints on spending growth, where it's not only limit growth at today's distribution of technology, but limit changes in technology that begin to move the locus of care.

MR. JOHNSON: A couple of things. One I wanted to talk about in this context too, the expenditure cap. In going back to Gail's letter to Nancy-Ann, in comment on page nine it talks about the expenditure cap being a short-term strategy and then the problems with the expenditure cap versus some of the other things we're talking about.

And then it goes down and says the Commission does plan to investigate options for volume and expenditure control in the next analytic cycle. Is that the March report? Are we going to have another recommendation? Is this part of what this discussion is --

DR. WILENSKY: The first thing is, this is a draft response, and we did raise this issue last year about -- I don't know if you recall the discussion. As I recall the gist of it in March when we talked about it, particularly because we recommended disaggregation which makes expenditure limits more appealing in the disaggregated system, that we ought to have an expenditure limit available. Although, as I recall the discussion, we thought it ought to be not too

tight unless it appeared that there was need for a tighter limit. That we thought the mechanism ought to be in place, but we were not advocating a stringent limit at this point time, in part because of some of the issues that Bill raised.

MR. JOHNSON: I agree. Then the other thing, just in this area, one thing that does concern me is the adjustment issue and the disproportionate impact on some of these hospitals, especially rural hospitals, in terms of payment adjustment and the losses there. I don't know if we'll address that later or not.

DR. LAVE: I must admit that indirect subsidies hidden are really sort of make life somewhat easier because when you see something like this and it pops up on you explicitly it...

Anyway, I want to come to Joe's first question and that is that I guess that I think that it would make sense to me to push for the same unit of payment for all of the sites that do things, whether or not they be the physician's office or whether they be an ambulatory care center.

But if you're talking about like things, it makes sense to me to worry about having the same unit of payment, which is not necessary to say you're going to make the same payment, because it does seem to me that there could be good reasons why you may want to make a different level of payment to worry about the fact that costs are inherently higher in some settings than in another and there's nothing that we can do much about it. And if we want hospital outpatients departments to exist, we're probably going to have to pay them more for the same service or than the same service at a physician's office.

The second question, it seems to me that having said that that then there are two different splits on this. One split is whether or not, in fact, the physician component and the technical component -- each one of these, as I understand it and I'm still struggling with this,

probably has physicians doing some of the stuff for which they get paid. And then there is a technical component to all of this.

It strikes me as if it's reasonable to think that the level that for five HCPCS I could have one technical payment, which would be sort of saying grouping on the technical side and splitting it out on the physician side. Or it could be vice versa, depending on how, in fact, it went.

I was looking, for instance, at upper GI endoscopy which is all in one APC and it has seven different HCPCS coming out of this.

So the question that I would have, for which I have no answer, is does it make sense to pay the physician different amounts for each one of these? Are these substantively different kinds of procedures, which is what they would under the physician payment system? And intuitively does it make sense that the technical costs should be the same for each one of these? Or should they be different?

DR. MATHEWS: When you say technical component, are you referring to the facility piece?

DR. LAVE: Yes, because that's what this really is. This is going to be the facility piece. So those are really two different questions.

If, in fact, God decided or somebody decided that it made sense to have the physician paid differently and the technical payment the same, that may be a perfectly reasonable thing but everybody would still be paid --the technical component would just be the same for each one of these.

Does that make sense, what I just said?

DR. WILENSKY: But in terms of our discussion --

DR. CURRERI: No, the technical component would be different for each of them.

DR. LAVE: No, but if in fact you believed that -- what I'm saying is that I could have something for which, in fact, the amount of physician effort involved, time, and so forth, is really quite different. But the supplies and the stock and everything else that goes into those are the same.

DR. CURRERI: Except the nursing time will be longer.

DR. LAVE: Then if the nursing time is different, then the payment should be different. What I'm saying is that you can have -- you might want to group things differently in configuring out the technical component than you did on the physician fee component.

DR. WILENSKY: Although, remember, to the extent that we're talking about having this be comparable, in the physician practice expense, they would also --

DR. LAVE: No, I would do the same thing in both of them. I would do --

DR. WILENSKY: Because that's not the case now under the practice expense.

DR. LAVE: No, but I'm arguing that -- I guess I'm arguing that I think you should have the same unit of payment for each of them, but there is no reason why the technical component for some services which would seem to be identical ought not to be the same. I don't know, it makes sense to me.

In terms of how you group it -- I mean, if it doesn't make any sense to group them on the physician side when they're provided, why would it make sense to group it in another setting if, in fact, they are very different?

So I guess to conclude, to me I guess it makes sense to have the same basis of payment in different sites, where if I'm doing an esophagus endoscopy, that's an esophagus endoscopy. It's not something different someplace else. But that it doesn't necessarily follow that

you have to have the same payment in every site, that you may want to, in fact, take into consideration, for some of these services differing payment. Maybe not for other ones.

To me you put all of the hospitals out of business if you say you're going to pay the hospital the same amount as a service at a physician office. And to me it just doesn't make any sense to say we want to put all of the hospitals out of business. But that's just my own opinion.

MR. SHEA: Do you want to vote on that?

[Laughter.]

DR. LEWERS: I don't know where to start. I have a number of comments that are just too lengthy to be able to give you now and I will give them to you at a later point. But I think some of the points I'd like to try to make, and I may ramble a bit, but you talk about three different sources of what you're talking about on those charts. But to me that's reality. That's where we are and that's part of the problem and that's Judy's problem. It's all of our problem, as to how do we compare one to the other.

And if I look at that list, I begin to wonder about the quality of care and where service is going to be rendered, in other words site of service because I think it is going to be shifted. The finances is going to cause a shift. And I think we need to point that out.

HCFA has already said that some of the things shouldn't be done in an outpatient department, some of the procedures, that they are not -- it's not safe to do them there. But they don't say it's not safe to do them in another facility which may have fewer emergency services than the other. So where are we going to go? We're already hearing that, in particular Judy brought up the GI, the GI people are very concerned about where some of their procedures are being performed right now.

And so I think this is a major element and it's not just payment, it's quality of care. I think that it's very clear that we have to point some of that out. And there has to be, if nothing more, if we're going to go ahead with this, we've got to have some way of tracking it, and some way of measuring it. And I don't know how you do that, but I think before this is implemented.

I have great concerns about this. I think the drawbacks to grouping way outshadow the benefits at this point, is I think what I heard Joe say and I've got some notes I made here. But it really does bother me and I don't know that we've got a lot of information on it.

I have some questions for you. In your Attachment A list, it says page number 47,566. Now that tells me something right there.

[Laughter.]

DR. LEWERS: I know what you're doing, that's all right, but there's got to be some humor somewhere in there.

[Laughter.]

DR. LEWERS: It says payment for non-emergency services rendered in an emergency department. That just stood out to me. That's an area we've just fought for the prudent layperson definition. I trust that's still persisting in this. I don't know, I didn't read that page unfortunately, but those are questions which I have which need to be brought out.

I go into -- I've got so many pages turned over here, I'll just have to give them all to you later, but I have a great deal of concern in our draft letter and I think this comes down to somewhat of what the thinking can occur when we end it in such a change, something that is so voluminous as this.

We state, it's the Commission's belief that this tension, the tension between the hospital and payment, will continue to exist as long as the physician is responsible for ordering

services. I mean, the implication there is that we're not going to order them anymore? I need to know who's going to order them if we're going to state that.

MR. JOHNSON: Maintenance.

DR. LEWERS: Maintenance is going to order them?

[Laughter.]

DR. LEWERS: But I think this is an area, in all seriousness, which is of major concern to me and something that is as drastic a change as this. When I read this, I thought who even thought this up? But that's another point.

I think we have to be very careful that we look at what is reality, what exists, and what exists in -- as Spencer brought out -- in rural hospitals.

The other area which I haven't heard mentioned here which is of great concern to me, because I've been doing some work in this recently, is the academic medical center. We're going to talk about graduate medical education, I guess that's tomorrow, and I'm glad that's going to be on every agenda. But I think we're putting a lot of centers in real jeopardy because we haven't been able to sit down and look in any detail as to what that is going to mean to that facility.

And right now, I'm very frightened about what's occurring in academic medical centers. Their costs are not being adequately reimbursed. Where some of it does come in it's being shuttled off either by a hospital or some other area into another area of the budget, which doesn't get back into the training of physicians. And so I have a great deal of concern -- and I'll give you most of it, if it will make any sense to you.

But I guess the question that I have, Gail, in ending, they have extended the comment period on this; is that correct?

DR. MATHEWS: It has not officially been extended. The word going around on the street is that it will be extended, but by only 30 days.

DR. LEWERS: That will take it to when?

DR. MATHEWS: Early December.

DR. LEWERS: I'm just wondering, we've had a lot of discussion and I'm wondering, before we comment, if there's any way we could have a time period to sort of sleep on this for a while after our discussion today. I think this is a major item for the Commission to comment on and I'm very worried that we can't do it in one session.

DR. WILENSKY: We certainly can do it. The only issue is that we will have to figure out -- depending on what happens with the timing -- how we convene for comment, which can either be by having people separately comment and not do it in some group manner, or we could have a conference call for people who wanted to have further discussion.

Do we have a sense about when the response will be due, if it is extended? Or not?

DR. MATHEWS: What I hear is early December, a 30-day extension.

DR. WILENSKY: We meet in the middle of November, so we certainly can -- Ted, I would like, just as a matter of factual clarification, that when you talk about paying academic health centers less for the services, it really is important to remember that although overall academic health centers have not had high margins, Medicare is really doing more than its share. I mean, the Medicare PPS margin for the academic health center for the teaching is like 20 to 25 percent.

So one of the questions that at some point we will need to discuss in some manner is that to the extent we want to provide subsidies for some institutions, maybe not all academic

health centers, maybe some academic health centers, for doing some functions, that we have to be thoughtful about what makes the most sense and whether every single service that is component should have monies added to it to make sure that other missions are done.

But we are getting to the point, in terms of payments for academic health centers, vis-a-vis Medicare, that -- I mean, it gets hard to imagine how much more than a 25 percent margin is appropriate. So it's not to say that some institutions may not be able to continue the missions that they've been doing in the past with this issue of what does it mean, how many of them, how do we want to intervene in terms of subsidy. We shouldn't only look at payment rates for service units as a way to make sure that there's enough money floating around.

DR. LEWERS: I'm not saying that that's what we need to do. But that's how many of the centers are being able to fund some of the programs that they're doing is on the some of the reimbursement issues. What I'm simply pointing out is that when we affect this change in certain areas, including rural and other areas, we are impacting some of those points. We're going to debate those other issues, I assume, at some other point in time.

But I just think this does filter down into that mechanism, and that's the point. I don't know how that filters. We had a slide on the urban/rural, et cetera. I just think there is some role in this and that's one of my concerns. Is there or isn't there? I don't know.

MR. MacBAIN: I have what turns out to be a follow-up on both of your comments, and that is that as we attempt to rationalize payment systems, we end up doing things that deteriorate the overall margins of teaching hospitals, rural hospitals, other vulnerable institutions. I really think we need to look at that and not get so caught up on what the individual margins are.

Now maybe it makes sense to find some other way to do it, but I think there's a serious risk here that we're going to get a payment system that may be a bit more rational and has

squeezed a lot of that "excess margin" out but hasn't produced anything else as a substitute for it. And we're going to end up with large gaps because teaching hospitals can no longer fulfill their missions. Rural hospitals are closing or scaling way back in their ability to provide care, and there's nothing else to replace it because we've squeezed money out of the system without recognizing that that money was being used, in some of these institutions, to achieve serious social good.

DR. LONG: A question on the section on the bottom of page 6, the top of page 7 concerning aggregate level of payment in the draft comment. The first is simply informational. When we talk about aggregate payment here are we talking exclusively about what's disbursed from Part B? Or are we including the copayments by the bene's?

DR. MATHEWS: This includes the beneficiary coinsurance. This is the total payment made in providing the service to the beneficiary.

DR. LONG: So that's not just --

DR. MATHEWS: Right, it's not just the program piece.

DR. LONG: And that's based on, when we say 80 percent of reported hospital costs, that's in the next fiscal year? Since the copayments themselves are going to continue to, as a percentage, to climb; is that correct? Is this just a snapshot for the next year?

DR. MATHEWS: This is just a snapshot, a given base year. I used '96 because that was the most recent cost report data that we had available.

DR. LONG: I guess one of the questions, and it in part relates to something that Joe raised earlier, as to what this is really telling us here. If I appreciate it correctly, since 1983 we have been rewarding hospitals for figuring out every possible clever way to shift costs into the outpatient side. Notwithstanding the best efforts of the regulation writers to constrain what can be done in the cost report, I think the fact is the hospitals have probably been pretty successful in

loading, increasing proportions of cost in the outpatient side because that's where we were paying for the costs.

That being the case, I don't know that I should be very worried that the aggregate payment is 80 percent of a cost figure that has evolved over 15 years of being artificially constructed. And do we have any basis, really, for worrying?

DR. MATHEWS: Depends on who you ask, I guess. HCFA believes that there is enough padding in here to go forward with the approach. Drafters of the BBA also believed that there was some leeway here. Hospitals don't believe that they can continue to provide services for 80 cents on the dollar.

I would refrain from commenting on it myself.

DR. LONG: Yet we're expected to comment on it.

DR. MATHEWS: You, not me.

[Laughter.]

DR. WILENSKY: I think one of the issues, as we're -- I mean, I don't know that we will come to agreement about the issues that you're raising, but I think we certainly can cite what we know about what is going on in the hospital world in terms of Medicare margins, overall margins, distribution issues to say it's really within this context. We're not going to answer it, but I think we ought to, at least, raise what we know about the financial viability and occupancy, utilization of the hospital as of the present time in the context of these recommendations.

DR. MATHEWS: Right. Given the disparity between the outpatient margins and the inpatient margins, it might be somewhat illusory to think of them separately in that sense. But what you're more concerned about is the Medicare margin.

DR. WILENSKY: Right. I think this whole issue of thinking about what this regulation and the BBA change will do, as is appropriate, is get us to focus on the whole hospital and not to think as exclusively on inpatient and outpatient, as we've been doing in the past. And I think that will be for the better.

DR. NEWHOUSE: I think where Judy and I are -- and I haven't heard anybody say anything to the contrary -- is that our goal would be a payment system that would be neutral between the office site and the outpatient department, which means not only the same basis but the same payment.

DR. LAVE: I'm not saying that.

DR. NEWHOUSE: I know you didn't say that, but let me continue. It seems to me our problem is that the costs of the outpatient department are higher, and I want to assume for the moment that that's entirely legitimate, either that there are differences in case mix between the office and the outpatient department, or there's standby capacity and so forth in the outpatient department that's not in the office. And that all of that is what we would want to pay for, so kind of the best case from the hospital side for reimbursement.

It seems to me then there's a couple of questions that arise. One is how much more do these higher costs apply as incremental costs for case? It seems to me that if we're going to have a different payment, that's what we would want to have. Even there that only, to say these costs are higher, assumes that somehow the mix of patients are given, we're going to ignore the incentive to shift patients.

The second is, and the one that I can't figure out in my own mind, is well yes, let's suppose that the bulk of these costs are more like fixed costs that are higher. The standby capacity to have around is more like the fixed costs.

Then it seems to me you need to figure out a way, if you can, to get money to the hospitals to cover these costs is not just reflected in a per case payment. When you put it in the per patient payment, then you give everybody the incentive to shift patients over to the outpatient department.

Now the obvious way to do that, it seems to me, if you were going to do that is to put it into the DRG payment. But what I don't know about that is how much risk you then run of distorting the inpatient/outpatient distinction. Let me put it another way. Suppose we said that all of these costs in the hospital are legitimate, just for the sake of argument. And for the mix of patients the hospitals are now treating, that's what they should be paid. Let's assume, for the sake of argument, that was both for inpatient and outpatient.

What we want to do is we want to pay those costs in a way that don't distort a lot of people that are now being treated in offices from going to hospitals, either going to the OPD itself or relabeling what's now the office building to be the OPD.

Then the only way, it seems to me, to do that then is to figure out some other way to reimburse these costs and then pay it through a much higher OPD visit rate. What that other way is I'm not sure, but the only way I can think of that seems easy would be the DRG rate.

MR. SHEA: Joe, just so I understand, this is so that you would be able to then pay the same for the same service, regardless of the setting?

DR. NEWHOUSE: Yes. It seems to me that we're really stuck because if it's the case that -- you know, cases differ. And the tougher cases are going toward the outpatient department rather than the office. And we don't have a case mix system that really recognizes that difference. Maybe I'm getting beyond reality here.

But then we're kind of hung either way. If we pay the same, then you've got costs going -- well, if we recognize the difference somehow, then you have an incentive to shift in. And if we pay the same, then either somebody's overpaid or underpaid for the mix that they have. So there doesn't seem to be a good answer here.

DR. LONG: Joe, in your model here are you assuming that this standby capacity is exclusively stuff that is there because of the inpatient capacity and not something that would be independent of inpatient?

DR. NEWHOUSE: Not necessarily. Could be or not be. I mean, some of it could be strictly outpatient capacity. Some of it could overlap inpatient.

DR. LONG: Then why should it be uniquely hospital outpatient departments? Why couldn't it also show up in an office somewhere? If it's not exclusively required because of the inpatient capacity?

DR. NEWHOUSE: If the tougher patients go there. Say the burn patients go there, so the burn unit -- now that would be mostly admitted, but that's --

DR. WILENSKY: But some of the emergency capacity you don't have in --

DR. NEWHOUSE: Yes, the trauma capacity.

DR. WILENSKY: You have trauma and emergency that you don't have. You don't have doctor's offices open 24 hours a day.

DR. CURRERI: A pharmacy doesn't run 24 hours a day in outpatient, either.

DR. NEWHOUSE: You may have a bigger inventory.

DR. LONG: I guess I'm not understanding why then the doctor's office is even competing with the hospital for those kinds of cases?

DR. NEWHOUSE: That's the problem. On the one hand, let's say it isn't for those kinds of cases. But then if you pay more, since you can't distinguish cases, then cases that are now going to the office would go to the hospital, some of them. Or there would be incentive to put them over there.

DR. WILENSKY: The question is whether you can adequately distinguish in the coding severity mix that we now use for what look like, on paper, the same patient? If you could distinguish them, then you could pay them differently and not induce movement.

DR. LAVE: I wanted to look at one of the comments that -- I have two comments. One is, do we know what an outpatient department is? That's one of the things that Joe keeps raising is are what used to be physician's office practices being converted into hospital outpatient departments? I simply don't know whether or not there is a definition of hospital outpatient department that would clearly distinguish between those things.

DR. NEWHOUSE: Why don't we stop there and ask Jim.

DR. MATHEWS: To answer your question, yes, this is happening and we can talk about this aside. It's very interesting.

DR. LAVE: That's a very important issue, it seems to me.

DR. MATHEWS: To follow up on that, in this outpatient proposed rule here, HCFA does propose to tighten the definitions of what they would consider a hospital outpatient department for purposes of paying for these services. I can give you a little more detail about what kind of characteristics they've outlined.

DR. LAVE: In our letter on page 7 we commented that there were two classes of hospitals that experienced broad reduction in payments, one of which is low volume hospitals which encompasses both urban and rural. I can understand why I'm concerned about rural low volume

hospitals. I can't understand why I should be concerned about urban low volume hospitals, unless these are really rural hospitals and only urban because of the way we define an MSA.

Because if I look around our MSA, some of the counties are really quite rural and they're really quite far away. But I would think if this were what the word urban strikes one as a low volume hospital, and since we are concerned about an over capacity in the hospital sector, it's not clear to me that as a Commission we ought to single out low volume urban hospitals as a concern, but that we may want to single out the rural hospitals.

DR. WILENSKY: It was part of what happened when everyone clamored to get to the higher payment.

DR. KEMPER: On the renaming of facilities, it seems to me that data on that would be useful but particularly monitoring that in the future.

DR. MATHEWS: There's no way to do it based on the information we have. There's no way to identify the hospital's purchase of a physician's practice or any other sort of contractual arrangement that shows up in how it's reimbursed.

DR. KEMPER: But how about just number of outpatient departments or something?

DR. MATHEWS: Yes, we can get that and see if there's some growth over time.

DR. KEMPER: Could they show up as different ones?

DR. MATHEWS: No, they would bill under the hospital's provider number.

DR. KEMPER: So you can't tell from that. It seems to me, going forward, that would be something to monitor, even with the tightening of --

DR. MATHEWS: I think that's intent of HCFA's language in the proposed rule on this point.

DR. KEMPER: Secondly, on this complexity or riskiness of the patients, do we have any data on that? It seems intuitively clear, but...

DR. MATHEWS: We've actually got a project in the works now that hopefully I'll be able to present the results of which to you in one of the winter meetings, where we're just going to look at a couple of procedures, because of the complexity of the analysis involved, and try and determine whether or not there are differences in the health status of the patients who receive these procedures that tends to influence the choice of settings.

So we'll have something to get to you there.

DR. KEMPER: It seems to me -- and maybe this gets too far from reality -- but if you want to talk about what you want to do, you would want to be able to have some distinction between high risk patients and low risk patients and be willing to pay for the standby costs and so on for the high risk patient and not for the low risk patient.

But if I understand it right, we can't do that right now. If you accept that it makes sense to have a common unit of payment across settings, which it makes sense to me, then it would seem to me that drives one toward allowing different payment rates in the short run and trying to develop some notion of measuring these high risk patients going forward, both monitoring it, monitoring the shifts that go on, and trying to develop what kinds of -- distinguish between patients where you would be willing to pay the higher cost.

That may not be feasible, but at least those data would be helpful in starting to see whether there is a difference and how it works. And you might be willing to pay for it in rural areas, in cases where you wouldn't in urban areas; for example.

I guess the third thing that I'd just mention is that the magnitude of the redistributions among hospitals seems to be very high. And I guess I wondered whether or not it

made sense to -- how fast it made sense to do that, to make this change? I mean, it seemed like, if I understood the data right, there's some fairly marked changes done in one year, if I understand it right.

DR. MATHEWS: That's correct.

DR. KEMPER: I guess my question is whether it makes sense to do things in a more phased way?

DR. MATHEWS: Part of those changes have already occurred. The formula-driven overpayment fix is in effect as of October 1st of last year, so it will show up in cost reports. As for phasing in the PPS --

DR. KEMPER: It's against the law.

DR. MATHEWS: Well, that, and there have been a number of recommendations, both from the professional community and predecessors to this community, that it would be ill-advised to do so, that it's best to get it over with in one fell swoop.

DR. CURRERI: I guess I want to express the fact that I'm not really very happy with this response, this draft response. I think that the areas where we agree with HCFA are rational and right. I think there's no expression that you've heard around this table today of where we think we're going wrong. And I'd list three areas that I think that this particular proposal is wrong.

I see no sense in doing to a temporary expenditure target and then to a sustainable growth rate maybe in the future. I mean, why not go to the sustainable growth rate and make it at least similar to the physician payment immediately. It doesn't make any rational sense to me to do that.

I don't see any rational sense, quite honestly, for going to this ICD-9 matrix with the APCs. I mean, the fact that it spreads it out to tenfold difference from the highest to lowest doesn't mean anything to me. I mean, what's the difference between that and a fourfold if the same amount of money is expended?

I'd like to see some data that proves that that is meaningful, that the ICD-9 actually is discriminating as to seriousness of illness and time and intensity that's involved in treating those folks. And I think that there's an awful lot of room for gaming in that because you can put ICD-9 diagnosis whatever you want from a whole list of things if you're going to get greater payment for a higher ICD-9 diagnosis.

But I think that troubles me most, and that was at the retreat and at the public meeting we had after the retreat. I think it was the consensus of everybody here, and I think we've heard this frustration today, that what we really wanted to go to was more uniform form of payment for all different carriers. What it seems to me this proposal is doing, this proposal for outpatients, is taking us the other way.

As Bill MacBain said, it's building different constraints and different silos, so we're all sitting here saying how are we going to remember all these rules and all these constraints and who's going to do what to whom. I really think we should say that the proposal needs to go further along creating a similar system of payment across the board, I guess as other people said, regardless of where the service is provided and how the diagnosis is made.

DR. WILENSKY: Could I ask you, if we put it that way we would presumably not object to HCFA doing some consolidation of CPT codes to get more grouping, as long as there was greater consistency between them?

DR. CURRERI: Right.

DR. WILENSKY: I just wanted to be sure I understood.

MR. MacBAIN: The more I look at some of the impacts, the more concerned I get about the dislocations that this approach is going to bring about. I realize some of that is the result of the FDOs and that's got to get fixed. But what I'm not clear on is what's the offsetting good that justifies all these dislocations?

If the goal is to restrain overall growth of expenditures, then something like the sustainable growth rate approach, as long as it can be adjusted for technology changes, makes some sense. Or if we could do that across the board. And that might be enough.

I'm not sure where adding all of this additional complexity for one little slice of the whole health care system, that is implemented alongside another complex system to pay physicians, and another fairly complex system to pay ambulatory surgical centers, makes any sense. Maybe I'm just being dense about it but I don't see where we're getting any good out of all of this that couldn't be achieved on a macro basis simply by a sustainable growth rate approach.

MR. SHEA: We recommended last year that the Congress should significantly change the phase-in of the change in the beneficiary co-pay here. Jim, you don't have numbers on the impact of the current phase-in rate on providers. I'm wondering if this goes forward in this fashion, does it make it much more difficult or much more expensive to then significantly increase the phase-in rate for the beneficiaries?

DR. MATHEWS: It depends on who pays. It's going to require additional outlays or additional --

MR. SHEA: Right. So let's guess that somebody might try to hand this bill to the providers. See where I'm going with this? Is this going to so cut payments that if somebody were to then come forward and say okay, let's do it in 10 years not 40 years or 5 years instead of 40 years,

the answer is going to be my God, we just cut these pay rates significantly and now this is going to cut them much, much more?

That's why I say you don't have any numbers in here that estimate the -- it doesn't seem like it's a big factor now, because the phase-in is so long.

DR. MATHEWS: Right, the incremental hit in any given year is fairly small. I wouldn't want to be in the room if this proposal would be made to increase the rate of correction at the expense of the providers, but I don't have any quantitative data.

MR. SHEA: Specifically, am I right in sort of intuiting that this will make the impact more severe?

DR. MATHEWS: Yes.

MR. MacBAIN: Just a question. In your example in here you used 50 percent as the real co-pay rate. I don't know if that's a nice round number. Is that in the ballpark, though.

DR. MATHEWS: That's close to the aggregate level of --

MR. MacBAIN: So the goal is to bring us from 50 percent down to 20 percent, that's a 30 percent difference.

DR. MATHEWS: That's correct.

MR. MacBAIN: That's a major hit.

DR. MATHEWS: Yes.

MR. MacBAIN: And if it all goes to the providers, that's a large chunk of the overall revenue. So it's a lot of money.

DR. NEWHOUSE: This may be better this afternoon when we talk about updating but since Bill Curreri and Bill MacBain keep coming back to it, I thought I'd say it now.

Bill MacBain actually slipped in the caveat that sort of gave the show away, I think, which was the adjustment for technological change. I mean, it seems to me that the issue with the same update system, SGR or whatever, is fine up to a point. But the real issue that we have to cope with is as technology changes, if God were doing it, God would adjust the pots to reflect that. And none of these systems is able to cope with that, at least directly.

So I think that's the issue we have to focus on, which may bring us back to the issue of should there even be separate pots. I mean, this is reminiscent of the discussions we had about the 1995 debates when there was going to be eight or I can't remember how many roughly separate pots of money, and how monies were going to be allocated among those various pots. I think that's the issue we probably have to focus on.

DR. WILENSKY: Any further comment on this?

[No response.]

DR. WILENSKY: Let me share some preliminary thinking about how we want to proceed with the comment letter. Your various individual comments were being listened to at both ends of the table and there will be an attempt to redraft our letter so that it is in more in keeping with both the recommendations that we made explicitly and with the views that were being expressed.

We will, because of the importance of this discussion, have it as part of our November meeting rather than attempt to do anything on conference call which does not allow us to share these discussions with the public. And it will probably be at the end of the first day, we'll have a session devoted to further comment on the redraft, hopefully final draft, of our comment letter in November when we meet.

DR. NEWHOUSE: Does that mean we'll run later on Tuesday?

DR. WILENSKY: Murray and I are looking at that. No, we won't run later on Tuesday. We will either run later on Monday or we will squeeze a little bit of one of the sessions so that we can keep exactly the same time. But you can plan to leave Tuesday at the time frame that's indicated, which is after 3:30.

But I did want to alert, for people who are interested in where the Commission is, on commenting on the reg, we will have this part of our public meeting probably mid to late Monday afternoon. If you look at the schedule when it's released for the meeting, closer to the time of the meeting, it will indicate specifically. But it won't otherwise impact the commissioners, in terms of departure.

If there aren't any further comments from the commissioners, you have more than your work cut out for you, Jim. We appreciate all the effort that you've made in providing this information.

I'd like to be sure we have time for public comments, so that people who are here and would like to say something, we will use this opportunity.

MS. WILLIAMS: Deborah Williams, American Hospital Association. I just wanted to talk about the issue of site of service comparability. It's an issue that I think a lot of researchers have looked at over the years.

Let's leave aside the issues of quality and I think that I want to leave aside a minute also the argument about where you establish incentives. I think, for example, when you look at the prior research that's been done, for example, in comparing ASC rates in the hospital OPD, it was always sort of troubling.

In my mind the ASC fee schedule, I always called it the invisible fee schedule. That is, it established rates for services that were never done in those settings. Or I believe Steve

Scheingold at HCFA found in the early '90s that the ASCs, for instance, would only do the cheapest or least expensive services in a group, those they felt to be profitable. While hospitals, for instance, might be doing all of the services in a group.

I know that when I was at my previous employment I tried to do a table that looked at, across settings, 10 services that were done commonly across all of them. And frankly, it was really, really difficult to find. So I don't know, when you talk about same payment rates, if those are services not done in those other settings I'm not sure what it means.

I think that actually Jim's work, and he did of course much more recent work, he also I believe found sort of not that much site of service substitution today. So you have these rates that are created from these cost data services for services that are never done. I don't know what it means, really.

So I would just urge caution when looking and making those kind of comparisons, especially if you don't have volume numbers associated with them. Thank you very much.

MS. FISHER: Karen Fisher with the Association of American Medical Colleges, which represents most of the major teaching hospitals, so I wanted to comment on that discussion a little bit. But first I did want to mention that I think the data and the data analyses that the MedPAC staff are doing is extremely important to this debate. There has been a lot of controversy and problems with the data that's coming out of HCFA and that's being made available to the public to perform their own data analyses. So I think the information that the MedPAC staff is doing is going to be very valuable in terms of what HCFA does and the impact of these different systems.

I also encourage the Commission, as you're going to do in November, to do and continue doing the analyses and to continue to discuss these issues, given that the comment period is going to be extended.

And it does sound like your discussion is focusing a little bit on the 30,000 degree level, in looking at payments across different types of services and sites of services, which is very important. To the extent that you do, though, I would encourage you to look at the variation within this payment system. If it goes into place, as it likely will go into place -- at least in the short term -- in terms of the variation and the impact across different types of providers, including the impact on major teaching hospitals.

Obviously, I thought Ted Lewers' comments were extremely insightful and informative, but I did want to point out, though, that I think it's important that when we start looking at Medicare payments and policies, that we have to more and more move to total Medicare margins, not just look at the Medicare PPS margins.

I know that MedPAC is moving towards that and is in the process of doing those types of analyses. Some of the Medicare payment-to-cost ratios that were included in the Commission's July data book indicate that if you translated those into a total Medicare type of margin, the types of margins you would see for major teaching hospitals are a lot less than what you would see in the PPS margin.

So I just urge the Commission, and I will be excited when the MedPAC staff are able to give you those total Medicare margins, because I think that's what's going to be important for you to look at when you look at future Commission recommendations. Thank you.

DR. CASEY: My name is Don Casey. I'm a general internist and I have a comment and then a question. I'm happy to see that the Commission has identified this issue of case mix and severity of illness as an assumption that is more empirical and does need to be fleshed out more exactly. I think that's important.

My impression is that hospital outpatient departments, whatever they are, at least my impression of them was that they were designed to gain market share of non-severely ill patients rather than severely ill. So I make that comment.

And then a question which was meant for the presenter, but perhaps the Commission can help me. I'm not an economist and I don't play one on TV, either. It relates to the use of relative weights that he was speaking about on the rate-setting panel of the hand-out, where the weight was determined as a ratio of the cost of services in the APC group divided by the cost of a mid-level clinic visit, which I presume means a level III established patient.

I'm wondering, even though I understand the use if the mid-level clinic visit as sort of at a high level, kind of obvious, easy assumption to make, as far as putting that in the denominator, I wonder whether it makes good economic sense and whether it actually reflects reality. It's just probably my ignorance more than anything.

DR. WILENSKY: Jim, you can come answer it. I assumed that it was just as a numerator, which you have to have something that you use as a constant and it doesn't really matter which constant you use because it's used across the board.

DR. MATHEWS: That is correct. I have to admit when I first read that proposal it gave me pause as well. And I did defer to the economists on our staff to set me straight on why that was done. And I'll defer to them now if they care to elaborate, but that is the essence of why it was chosen.

DR. WILENSKY: So it's a common denominator and everything can be translated into it, as opposed to reflecting something in particular.

MR. CASTLE: I'm Gene Castle with the American Psychiatric Association. We would hope MedPAC would look at the issue of partial hospitalization services and do some

analysis of this and the validity of the numbers they come up with, the methodology. We're kind of at a loss ourselves on this, and would like some input.

MR. GUTERMAN: The staff is developing some plans to take a look at that.

MR. CASTLE: I would appreciate if you would talk with Al Dobson from Lewin Group on this, because we're having Al look at this, also. Thank you.

MR. SHEA: What was the nature of the request?

MR. CASTLE: Partial hospitalization.

DR. WILENSKY: Treating severely mentally ill patients? Yes.

MS. CLARK: I'm Maryanne Clark from Covans Health Economics and Outcome Services. My question has to do with drugs and drug reimbursement. I'm wondering if there's any indication right now, especially on the APCs for chemo-therapeutics, how much those are actually going to change in the final rule, because there are some severe problems with those.

For example, they might have several different dosages of the same drug in the same APC, but yet my understanding is that a hospital can bill multiple APCs. For example, if a 100 unit dose and a 200 unit dose and

a 300 unit dose of the same drug is in the same APC, a hospital provides 300 units, they could bill either three APCs of the 100 milligram unit drug or one unit of the 300 milligram. I was just curious if you've heard if that's being addressed?

DR. MATHEWS: Yes. We've gone through the rule. At least one of the issues that HCFA has not solidified their thinking on yet, and are soliciting input from professional representation. So it's likely that the final rule will be somewhat different than what is in here.

MS. CLARK: I guess another question has to do with the prosthetics and orthotic devices. Most of those are going to be paid under the current fee schedule. However, there are

many different prosthetics and orthotics that don't have a separate fee schedule amount right now and they're paid based on the revenue center. So does this mean manufacturers should be going out and getting codes for these, so that they can get a fee schedule established and be paid according to a fee schedule?

DR. MATHEWS: I couldn't advise what the manufacturers should do.

[Laughter.]

MS. CLARK: One of the examples is pacemaker implant. There's no really HCPCS code for that and it's billed under a revenue code. And that's outside of the surgical grouping system.

DR. WILENSKY: Thank you. Are there any other comments?

[No response.]

DR. WILENSKY: It's clear that the Balanced Budget Act not only is providing employment for lobbyists and lawyers, but economists and consultants, as well.

DR. LEWERS: Madam Chair, a couple of us have questioned whether or not we could have a break about 10 minutes of 2:00 until about 10 minutes after 2:00, to watch the Glenn liftoff, assuming it's on time. It's a very historical event, and I don't know whether we can even get a TV in here that we could all watch it. But my personal feeling is that I'm going to have to leave the room and I don't know that I trust all of you while I'm gone.

[Laughter.]

DR. LEWERS: We could come back early.

DR. WILENSKY: Exactly. Why don't we reconvene about 10 minutes early. It's only a little after 12:00 now and we'll reconvene about 1:20. We will see whether there's a

possibility of bringing a television in here. That would make it a lot easier than having people scattered to the winds.

DR. LEWERS: Thank you.

[Whereupon, at 12:07 p.m., the meeting was recessed, to reconvene at 1:32 p.m., this same day.]

AFTERNOON SESSION [1:32]

DR. WILENSKY: Kevin?

DR. HAYES: Good afternoon. We're here to talk about a work plan for physician payment issues that can be -- issues that can be addressed in the Commission's upcoming March report.

The first slide here lists the general categories of issues that we might address in the report. They fall into three areas: practice expense, malpractice expense, and the sustainable growth rate system.

If we look first at practice expense, let me remind you first that we're awaiting a final rule from HCFA which will include the practice expense relative value units that will be implemented in 1999. I have a little more information for you than what I was able to put in the work plan, and that is that that final rule should be published in the Federal Register next week.

DR. LAVE: Calendar 1999 or fiscal 1999?

DR. HAYES: Yes, calendar 1999. January 1st, 1999 is when the values would be implemented.

The staff will review the rule, of course, whenever it comes out and if there are some additional issues that surface there, we'll of course bring them to you. But in the interim, we feel like there are several practice expense issues that will probably not be fully resolved in the final rule and we thought we might talk about those today as possible candidates for the March report.

The first of those has to do with refinement. While we're anticipating a final rule from HCFA, we know that the practice expense RVUs in that rule will be interim. That is, subject to refinement. Previously, HCFA has said that they'll be interim, at least until the fall of next year. We'll see what the final rule has to say about that. But in any case, we can anticipate that there are some refinement issues here.

Some of them are pretty specific, having to do with the review of the direct cost data that HCFA is using from those clinical practice expert panels, or CPEPs, that you've heard about. Other issues are broader in scope. I'm thinking here about the data HCFA is using on physician's aggregate practice costs. The Commission, for its report, can review these various issues and perhaps take a position on how they should be addressed over time.

The second topic that we might take up has to do with the volume and intensity adjustment. This is an adjustment that HCFA anticipates using to adjust the fee schedule's conversion factor for expected increases in the volume and intensity of services when the resource based values are implemented.

The latest news here has to do with an analysis that HCFA is basing this adjustment on. This was conducted by the actuaries at HCFA and that analysis should be released simultaneously with next week's rule. So we will have an opportunity then to review that analysis and critique it and that would be something that we could address, as well, for the March report.

The third topic, something that came up this morning, has to do with site of service differentials. Coming at this issue of site of service from the standpoint of physician payment, we know first that there is a current policy in place which reduces practice expense payments by 50 percent for some services if they are provided outside of an office setting, in a hospital outpatient department or ambulatory surgery center.

That policy will change when the new values are implemented. The site of service differentials will then become service specific. So from our standpoint, one thing we might do is to just monitor -- I should back up and say that those differentials will change such that, in some cases, the differences between payment rates between in-office and out-of-office services will grow later, and in other cases they will grow smaller.

In any case, what we will want to do, I think, as part of our work, at a minimum, is to just monitor changes in site of service over time as these differentials are implemented.

The other thing that we've talked about doing would be to maybe integrate our work on monitoring the site of service with our work on monitoring quality of care of Medicare beneficiaries. I've talked to Beth Docteur about this idea some and it would be a nice way, I think, to integrate some of our work on physician payment policy and quality of care.

Moving on now to our next topic, which has to do with the malpractice expense relative value units and the fee schedule, the Balanced Budget Act of 1997 requires that resource based values be implemented in the year 2000. Toward that end HCFA has awarded a contract to KPMG, Peat, Marwick to have a set of resource based values developed. The work of the contractor is expected to be concluded in time for release of a proposed rule with a set of values by the middle of next year, 1999.

While we can address this issue to some extent, I would think, in the March report the real substantive work of the Commission will come when that rule is issued and we'll, of course, want to review it and comment on it.

The final topic would be the sustainable growth rate system. As you know, this is a system used to annually update the fee schedule's conversion factor. The system is still fairly new in that it was created by the Balanced Budget Act. We're still awaiting the first conversion factor update, the one for 1999 that will be based on this system. But nonetheless it could be, and from what I gathered from the discussion this morning, this probably will be a topic for the March report one way or the other.

Certainly there are some physician specific issues that we could address, and then there's the matter discussed this morning of possible expansion of the system to encompass hospital OPD payment rates and so on.

So that's really all I have to say. I just wanted to get you started.

MR. MacBAIN: A question on table one of the stuff we got in the mail. The rates on table one, are those the physician only rates when comparing office versus facility? That is what the physician gets paid?

DR. HAYES: That's correct.

MR. MacBAIN: Can you produce something similar to this that shows the total cost to Medicare or Medicare+ beneficiaries who are serviced in the office versus in the hospital? I guess that's two questions, really. Total cost to Medicare and then total cost to Medicare and beneficiaries, the total cost of the service.

DR. HAYES: The rates that you see here are Medicare's allowed charges. So they would include the beneficiary payment, co-payment, as well as what the Medicare program --

MR. MacBAIN: For the office visit, but not for the OPD, which would include the 20 percent?

DR. HAYES: That's correct. So you'd want to see a complete set? Sure.

MR. MacBAIN: Again, just trying to draw all these pieces together, so we get a look at the whole...

DR. NEWHOUSE: There was a figure in our handout, Kevin, that you didn't put up?

DR. HAYES: Right.

DR. NEWHOUSE: Should we ignore that?

DR. HAYES: No, we can talk about it if you'd like.

DR. NEWHOUSE: I just have a couple of questions. One is what is the difference between the annual VI per beneficiary and the average VI per beneficiary?

DR. HAYES: For the group, let me just explain what this overhead addresses. I made some points in the work plan about the components of the sustainable growth rate. One of those components is real GDP per capita. What this slide does is it compares what CBO is projecting in the way of real GDP per capita with what we have actually seen with respect to volume and intensity per beneficiary growth from 1992 through 1996.

DR. NEWHOUSE: Where's the CBO projection here, since everything seems to end in '96?

DR. HAYES: The CBO projection is the bottom horizontal line denoted by the circles, and it is an average projection for the years 1999 through 2003. That is 1.2 percent. It varies. It's in a range of 1.1 percent, I believe, up to 1.5 percent. But I just wanted to put that average on there, which could be contrasted with the average experience we've had with volume and intensity growth per beneficiary, which is the horizontal line denoted by the triangles just above that first one.

DR. NEWHOUSE: That's for '92 to '96?

DR. HAYES: That's right. Just trying to provide some perspective on what volume and intensity growth has been like and what the projection is for real GDP per capita growth.

DR. LAVE: So is that sort of the number of the average of the real number that you have here?

DR. HAYES: Yes.

DR. LAVE: That average VI per beneficiary is kind of the average of the erratic points?

DR. HAYES: That's right.

DR. NEWHOUSE: So this was the rationale for the old PPRC recommendation of GDP plus one to two, is what you're getting at here?

DR. HAYES: That's right.

DR. NEWHOUSE: The other issue I wanted to raise was the malpractice issue. Back in the PPRC days, as you say, we were interested in a differential that varied by service on the grounds that the risk of a claim and/or damages was very different for invasive procedures than for non-invasive procedures. The method that seems to be contemplated doesn't account for that. I mean, we don't know what KPMG will do. But nothing so far indicates that.

So I'm wondering if this would not be a good time to reiterate that recommendation, assuming we agree since this is a different set of people now than in the PPRC world. But we might have some discussion here of whether people agree with that.

DR. HAYES: I don't want to preempt anything, but we could have a discussion now if you'd like or the staff could generate a background paper for the Commissioners, just to bring the group up to speed. We could then move forward with whatever communication we want to make with HCFA. That would be one way to handle this.

DR. NEWHOUSE: That may make sense.

DR. WILENSKY: When you had the previous slide up, can you relate what was on that slide to the actuaries now believing a 30 percent offset assumption? I wasn't quite sure how those two related to each other.

DR. HAYES: I'd want to think about that one a little bit. I don't know that we can get there with this overhead.

DR. WILENSKY: I mean, these are not related to each other. That is what the HCFA actuaries are using. Do we know if that is based on analysis or some empirical data that they have? Or that's just what they've stated that they believe is their basis?

DR. HAYES: I haven't been able to get any information on the details of that analysis at all. I'm anxiously awaiting the release of it. It's something that we mentioned in our comment letter to HCFA as being important, and I'm just glad to hear that it's finally going to be released. It will be put up on their website, from what I understand, next week whenever the final rule is issued.

DR. WILENSKY: That would be part of the comments that would be in the final rule about why or how they responded to various comments?

DR. HAYES: Yes.

DR. LEWERS: Following along what Joe is speaking of in the liability area, obviously is the term I'd prefer rather than malpractice. In your paper, from what I get is it's all specialty specific. There's no geographic, there's no variation at all. Because that's a major variant. If those states have tort reform rates are lower than they are in other areas, we're basically going to take the broad average? Is that what you understand?

DR. HAYES: They'll be taking a broad average and coming up with a set of relative value units, but then the fee schedule's geographic practice cost indexes will be applied to that average.

DR. LEWERS: So they will be applied in the broad context, not -- because malpractice in the RBRVS is 5 percent. So if we're going to take it in the broad we're going to have

a skewed value, it would appear to me. Maybe if you're going to do a background for us, you might cover that. That's an area that -- you compare New York to California, and the changes that have occurred, and there's a huge difference.

So I don't think you can take the whole context and say we're going to do the geographic purely on the basis of the final number or the final formula. I think it's different. I don't know what they'll come up with but...

DR. CURRERI: Isn't the GPCI applied to each of the three segments?

DR. HAYES: Yes.

DR. LEWERS: Well, that's the question, is it going to be? Because the paper says it's not. It says it's specific to specialty only. I guess that's my confusion.

DR. HAYES: That's right. What we'll address then in the paper are the relative value units themselves and how they were calculated for the current set of relative value units. That's based on methods that were identified way back in 1989 when OBRA '89 established the fee schedule itself.

We can also talk about the PPRC's proposal for a so-called risk of service method for developing the values. And then we can talk about this third method that HCFA has identified for the contractor as a way of doing things. That would be one set of issues specific to relative value units.

We can then separately talk about how those relative value units are adjusted by the geographic practice cost indexes and show you some examples of what effects the indexes have on the malpractice expense RVUs. How's that?

DR. NEWHOUSE: Kevin, do you have any sense of why HCFA has not pushed forward with some malpractice or professional liability adjustment that reflects the likelihood of a

claim or the expected value of a claim and has ignored that issue? I mean, do they think this is administratively impractical? Undesirable? Too small an amount of money to matter?

DR. HAYES: You're talking about the methodology that's been proposed for the contractor and why it is of such a limited scope?

DR. NEWHOUSE: Yes, and the prior methodology before that. It never seems to come onto the table that you might want to put in a bigger malpractice adjustment for invasive stuff than non-invasive stuff. I'm wondering if that's been considered or rejected or overlooked or where things -- why this hasn't been considered or doesn't seem to have been considered?

DR. HAYES: I don't know the answer to the question. My assumption is that it has something to do with the availability of data, but I'll be happy to look into it and see what I can learn.

DR. NEWHOUSE: There are some data.

DR. LEWERS: Joe, I think that's exceedingly difficult, probability of claim on the basis of whether it's an invasive procedure or non-invasive procedure, there's so many variables there. The probability of a claim comes a great deal with the practice of the physician, the recordkeeping, the personality of the physician. So I don't know that you can say just because it's an invasive procedure that there is a probability, per se, that you could come up with. I think that would be nice if you could do that, but I don't think you can.

DR. NEWHOUSE: I did that off one database, it wasn't a national database. This was before failure to diagnose had become as big a deal as it has become, but in those days there was literally a tenfold difference in the likelihood of a claim. I mean a tenfold greater likelihood for an invasive procedure. So this is not a small difference.

DR. LEWERS: You're not talking per procedure? You're talking invasive versus non-invasive?

DR. NEWHOUSE: And I was also looking at different procedures, as I recall. It's been a few years. David Shapiro may recall what this was. But I think I looked at specific procedures.

But in general, and it didn't seem at all surprising to me since we know claims tend to be filed for errors of commission rather than errors of omission, but errors of commission would be strongly associated with procedures or invasive procedure.

DR. LEWERS: I think that's changed dramatically.

DR. NEWHOUSE: Failure to diagnose has certainly gone up but as I say, it was a factor of 10. So it seems to me unlikely that it's gone away.

DR. LAVE: I want to come back to this issue of the sustainable development versus whatever, the expenditure targets.

DR. WILENSKY: Sustainable growth.

DR. LAVE: Sustainable growth versus the expenditure targets. I've been thinking a little bit about the outpatient departments and the physicians and why would we want to think about them separately? Why, in fact, would we care about where the overall dollars went as opposed to the overall bundle? The disaggregation opposed to the aggregation.

One of the things I was wondering about was have you ever done -- I know that the outpatient services, I believe, have gone up faster than physician services. But have you ever done anything in terms of looking at the site of care for physician practices? So supposed I looked at all of the physician services that took place on the outpatient side as opposed to the inpatient side. Would I find that they were going up like the outpatient stuff?

It seems to me that that would give us a way of sort of thinking about these things collectively, as opposed to thinking that the outpatient services somehow or other are separate

from physicians, whereas I think that for most outpatient services there was probably a physician component that's attached to it through another thing.

I think that might be helpful, to help us think about the broad picture that's taking place that we have to keep our eye on. That is the practice of medicine is changing and focusing its component parts, I think, lets that slip away a little bit. I think that might help us a little bit.

DR. HAYES: Okay.

DR. KEMPER: This is a comment that I really was going to make in the next session. But with respect to the sustainable growth rate, it seems to me it would be useful to have that background work not done in isolation but really look at the update, the hospital updates and other updates, the increases in the risk payments, and the physician sustainable growth rate all together as one set of analyses. Look at total Medicare expenditure growth, what the reasons for that are, and talk about technology in the context of all of those areas, to try to introduce some coherence to the strategy.

And then go into the specific ones, where there's specific requirements and so on. To me it's the same set of issues across all of them and ultimately it's a very political decision about these updates. But I think there are things that can be said about contributing factors and technology and what the implications might be of different rates of growth.

DR. WILENSKY: It turns out this attempt to bring the world at large to us hasn't worked quite as well. They can't get a cable hookup for this. There's apparently a large screen at the top of the mezzanine and we will take a break and reconvene by 2:10.

[Recess.]

DR. WILENSKY: Okay, Ted --

DR. LEWERS: Thank you, ma'am.

DR. WILENSKY: I don't know whether people had any additional questions or comments they wanted to ask Kevin before we finish this section? Ted?

DR. LEWERS: I guess one of the areas that there was some discussion is oversight, tracking of all of this, the SGR, et cetera. Those of us from PPRC on physician payment, we had to give a report, as did HCFA, every year. That's gone with the BBA. HCFA's supposed to be doing an SGR report on an annual basis, but I don't think one's been released. Is there any oversight or should we comment about the lack of oversight on what's developing here?

It seems to me there needs to be somebody to track this and to take a look at what's happening, and I don't see it happening.

DR. HAYES: Maybe that's a role for this group. What I talked about in the work plan was the possibility of our monitoring growth in Medicare's physician payments and looking at the components of that growth, changes in payment rates, changes in the volume and intensity of services.

Some of that work was done for the trends report that we put out in July, and I could see where we could expand the scope of that work some and just kind of view that as just a regular part of our monitoring work. That would be one response.

To go further, I guess we would just have to make a recommendation what, about HCFA taking on some further responsibilities, much like what they had in the past. Comment on the timing of the release of the SGR information that you referred to. Those are all fair game, I think.

DR. LEWERS: Gail, do you think that is -- I think that's something that we should do. There's no one, as I see, tracking this sort of material any longer, now that the BBA took us out of it, basically. It took PPRC out of it, so it took us out of it.

I've just got to feeling that's some sort of oversight.

DR. WILENSKY: I don't know of anything that prevents us from doing that, so I guess it would be only what we would need guidance on is if we were to do that -- and I think that given the changes that are going on, both in terms of Medicare and Medicare vis-a-vis the rest of the health care system, it's appropriate to monitor what the impact is on physician participation, behavior, access of seniors, et cetera.

You just need to alert us that if, by doing that, there's something that we are not doing that we thought we were doing, so that it has an impact that we need to judge more explicitly.

DR. CURRERI: Kevin, could you refresh my memory, does the BBA make the sustainable growth equate to growth in GDP in perpetuity? Or is there any flexibility?

Our recommendation, so as not to cut off technological advancement, was to have GDP plus some increase in factor. I am still concerned about linking it strictly to GDP because I think, for technological advance, you're going to have to cut something else out, which may or may not be advantageous.

So would that require a new law or an amendment to the law? And if so, shouldn't we analyze this? I suspect we made our recommendation based on very little data but gut feeling. But I think we should try to accumulate, if the rest of the commissioners feel the way I do, some data that would substantiate something more than just GDP. Or to introduce some sort of flexibility so that at certain times there could be an increase greater than GDP.

DR. WILENSKY: We definitely had recommended GDP plus something. We did not have much basis, specific basis, for what that something would be other than the fact that we wanted to allow for cost increasing technologies to be able to be introduced. Are you suggesting

that we do this monitoring immediately? Or that we allow some time to pass, a year or so, to try to see what, if any, impact comes from the sustainable growth rate?

We could always just reiterate the recommendation that we made previously, that we think that -- assuming the Commission were to feel this way -- that the better course would be GDP plus some positive amount and not do anything more analytical than just reiterate our recommendation.

DR. CURRERI: You probably know better than I, but it seems to me Congress rejected that.

DR. WILENSKY: It does seem to be that way.

DR. CURRERI: Then I think that the only way to perhaps change their mind is to produce some sort of data that suggests that this is slowing down the technological improvements that might be implemented. Because in the long run it seems to me that technological advancements often, in the long run, result in reduction of expenses. So it seems short-sighted to me to essentially limit or to impede new development in these areas.

So I think we should start now. If we wait a year or two, then it will be a year or two analysis after that and we're way down the line by that time. I personally think that we ought to try to accumulate some data that would be convincing to Congress that this was an error, that there should be some flexibility so that Congress could increase it by some positive amount over and above GDP.

DR. WILENSKY: Maybe for our next meeting, Kevin, if you want to think about the kinds of monitoring that might be feasible in the short term, we can see whether or not that's something that's supported by the commissioners.

Any further comment on the section on the physician payment work plan?

[No response.]

DR. WILENSKY: Thank you. Stuart, setting and updating payment rates, an issue we've obviously broached several times already today.

MR. GUTERMAN: We thought about whether we should have the broad discussion before or after some of the applications, and it turns out that it's probably good to have it this way. A lot of the issues that I'll be getting at have been referred to in the discussions that have been had prior to this today.

I'm going to, in this segment of the agenda, walk through some of the basic elements of payment systems. MedPAC's mandate includes examining and commenting on the development of several new systems and recommending improvements in existing systems. As you consider those new payment systems, it would be helpful to keep in mind the types of decisions that need to be made, the way these decisions have been made in different existing applications, and the factors that determine how those decisions have been and might be made. That's my purpose today.

Also, laying out and keeping in mind a consistent framework in approaching these decisions highlights and illustrates MedPAC's concept of consistent payment policies across providers and may remind us that consistency is not the same as uniformity, and help us get at what we mean when the Commission says that payments should be consistent across settings.

The intention, our intention, is to turn this discussion into Chapter one of your March report.

In the first overhead, just sort of housekeeping, there are, of course, alternative approaches to determining payments in a payment system. We are going to focus today on what I call prospective payment systems, which are simply systems in which a payment rate is set in

advance for a definable unit of service or other commodity and using that broad definition of prospective payment, we can apply that term to a lot of different approaches taken in the Medicare program.

In the next overhead, the Balanced Budget Act called for the development and implementation of a number of new systems, and there are several other actions that HCFA was getting ready to take anyway that will result in the same kinds of decisions having to be made in different applications. There's the skilled nursing facility prospective payment system and that was implemented on

July 1st of 1998, a few months ago.

There's a physician practice expense approach that was laid out by HCFA in a proposed rule and, as Kevin mentioned, the final rule is due out soon.

There's an ambulatory surgery center payment system that was not required by the Balanced Budget Act but nonetheless HCFA came out with during the summer and the Commission commented on, although they've delayed the final implementation of that system -- which was originally scheduled to go into effect on October 1st -- until sometime in the year 2000.

There's the hospital outpatient department system that Jim was talking about this morning. There's a system for home health agencies, a prospective payment system for home health agencies, preceded of course by an interim payment system, that has attracted a lot of attention both in Congress and on the MedPAC staff.

There's a system scheduled to go into effect for rehabilitation facilities as well. The BBA also required HCFA to develop a system for long-term care hospitals and report to Congress on the system with the presumed intention of implementing it if it was satisfactory.

In addition, one point I'd like to make, and I'll return to regularly, is that the Medicare+Choice system can be viewed from much the same kind of framework as the provider oriented payment systems, in that there's a rate paid that's set in advance, that the entity that receives it has to sort of live within. And there are many other characteristics that the Medicare+Choice payment system has in common with the prospective payment system for providers.

In the next overhead I have a list of existing payment systems, again calling them prospective payment in terms of my very broad definition of that term. The hospital inpatient PPS is probably the primary example. It's certainly the largest standing large example of a prospective payments system. I'll be referring, as I walk through the potential components of a prospective payment system and the kinds of decisions that have been made, I'll be using the hospital inpatient PPS as an example, although contrasting and comparing it with some of the other systems that are in place or are being developed.

The physician work component of the Medicare fee schedule can similarly be viewed as a prospective payment system and share some of the characteristics.

The existing ambulatory surgery center payment system, although it's very different than the one that's been proposed, still involves the development of a payment for a defined product. And then there are others, laboratory, durable medical equipment, and several other categories of products that Medicare buys that are paid with a fixed rate.

In addition, as I said, the Medicare risk program can be considered a prospective payment system, as well. In fact, it helps, as you saw last time when you talked about risk adjustment, to consider some of the parallel concepts with prospective payment.

The Balanced Budget Act changed the risk program, of course, into the Medicare+Choice program and expanded it considerably. It actually made the Medicare+Choice program even more like a prospective payment system then the old risk program in several ways. For one thing, severing the payment rate for risk plans from the current projected fee-for-service spending per capita meant that some decision had to be made about how to update the rates from year to year. And that kind of decision is sort of parallel to the fee-for-service element.

The BBA called for a risk adjustment to be applied, and that is directly analogous to a case mix kind of system in a fee-for-service payment.

There was also a move toward a national rate by blending local and national rates. That introduced the requirement for a geographic adjustment of some sort, and you'll hear much more about that tomorrow morning when Sarah talks about that issue in the Medicare+Choice program.

So the first thing you need when you are going to make decisions is a set of objectives. In the next overhead I've listed four sort of broad objectives that seem to be common to prospective payment systems. I'd be interested in the Commission's discussion of what they view as good objectives to add to this list that apply sort of across the board when you're considering how to develop a system.

To me the primary objective of a prospective payment system is system-wide efficiency. There's some notion that you ought to provide a set of incentives that allocates resources appropriately within the system. That is really connected, which is why I sort of put the continuous wording there, with access to high quality care. I think the notion is that the Medicare program itself exists to provide access to high quality care for its beneficiaries. Designing a

payment system within that program should have the requirement that it at least does not harm that access.

Also frequently, in designing individual systems, there's a notion of provider level efficiency that is providing an incentive for each provider to minimize the cost of providing each unit of service. And then frequently in these systems, there is sort of a public goods rider that the Congress frequently uses to achieve some broader public good. One primary example of that that the Commission will be spending a lot of time discussing is graduate medical education in hospital payment.

There are other considerations on the next overhead. These considerations sort of describe the kinds of things that you have to think about when you're making the decision. I'll be presenting a set of sort of basic elements of prospective payment. The thing you have to consider in discussing each element in each application is that there are factors that might lead you to make different decisions when you're developing a prospective payment system to apply to a particular circumstance. That gets at a lot of the discussion you had this morning about consistency across providers.

So you can sort of view this as a matrix in your mind, where you have types of providers or types of services or generally circumstances to which you're going to apply a payment system. Then the set of elements that I'll put up in a minute as the lines. And then each cell represents a set of decisions that has to be made in the design of that system.

One factor that determines the decisions that are made in each circumstance is the nature of the service. That, for instance, could lead you to make different decisions when you're designing a system for hospital inpatient services than for hospital outpatient services or ambulatory surgery centers or physicians, not to mention post-acute care in its various settings.

Another is coverage policy, and that particularly comes up when we talk about home health care because frequently the payment policies that are attempted under home health are done because they're trying to address problems with coverage and the fact that coverage under that component of the program may not be as well defined as people would like, or may be being used in a way that may have been inconsistent with the original intent of the program.

In any case, you have to consider how coverage policy relates to the ability of payment policy to accomplish particular objectives.

Another is, as the Commission has stated consistently, consistency across related services and providers. And there are at least two sort of objectives. One is neutrality, as you've stated many times, that you don't want the payment system to determine where a service is provided. The other is a lack of conflict. There's a general notion that the system ought to be fair across providers, that it ought to pay the appropriate amount, and that there ought to be some consistency across systems to allow the evaluation of that consideration.

Another major consideration, and one that may drive a lot of decisions that are made in designing payment systems, is the underlying data. That has two components. One is what information is available and how accurate it is and what the cost is of obtaining that information. Sometimes, for instance on the hospital inpatient PPS, the availability of cost data is so much greater than in many other settings and so much more reliable that that may have driven a lot of decisions in designing that system, whereas on the physician side the cost of individual services is basically not known. That could cause differences in the kinds of decisions you make in designing a payment system.

Also, there's the structure for collecting the data and how costly and how involved that would be. That will have to do a lot with considerations in designing a Medicare+Choice payment system, or at least implementing modifications of that.

To the nitty-gritty. I have a list of basic elements of a system and these are the kinds of decisions that basically you need to make regardless of the system you're constructing. The first element is -- and you see I have them sort of grouped.

The first element is the unit of payment. There we're talking about basically the unit for which the provider receives payment and there are considerations to make, such as how closely the unit of payment should correspond to the unit of service that the provider views as being his or her job, or that the payer views as being the product that it wants to purchase.

There, how you apply the decisions that you make may have a lot to do with the historical evolution of that sector of the health care system. For instance, on the hospital inpatient PPS, the unit of payment is the discharge. That actually was an explicit decision that was made at the time that that system was designed, to move from the sort of commonly accepted unit of payment prior to that, which was the hospital day, to a broader unit that would encourage a change in the thought of how providers viewed the service that they were providing to the program.

It also allowed the Medicare program to sort of get out of the business of paying for every single service that the hospital provided and encourage a broader way of thinking about the product that hospitals provided.

The physician payment system represents a different set of decisions. Physicians are paid based on the individual service that they provide, and that may have to do more with how the providers view the services that they provide and the history of how they paid for that service.

In your discussion this morning about hospital outpatient payment, that issue comes up. What's the right unit of payment and how do you structure the payment to fit both the requirement for consistency and the requirement to sort of portray how the service is provided in that setting. That's one of the big differences between settings, and it's one of the big considerations that sort of stands in the way of just moving to a uniform type of payment system across providers, that these providers -- for better or for worse -- do seem to behave differently and do seem to structure the provision of their services differently.

The Medicare+Choice program also has a unit of payment component. The unit of payment there, though, instead of being a unit of service is a unit of time. It's the person-months. But it can be viewed the same way. The plan gets paid for every person-month that it provides to the Medicare program, and decisions have to be made about what the appropriate way is to design that payment.

The set of incentives, obviously, is very important. If you pick a unit of payment that's broad you provide an incentive to reduce the amount of services that go into each unit. So if you pay on a person-month, you have an obvious incentive to provide fewer services per person-month. If you pay on the basis of the individual service, you provide an incentive to increase the number of units of service. That's a large piece of the concern that leads to discussion of expenditure caps for physician services and for hospital outpatient services, because you're paying on the basis of the individual service.

There was some concern when the hospital inpatient PPS was developed that hospitals would try to increase the number of admissions. HCFA, in fact, was required to report to Congress on methods of controlling increases in hospital volume. Well, it turned out that the trend

was the other way. That's another consideration to make, who's making the decision about how many services are being provided.

It turned out that there were two factors. One is hospitals couldn't the number of admissions because it's the physician that largely has that decision. The other was that every other trend was going the other direction. Technology and the practice of medicine in general was leading to the increased provision of services outside of the inpatient setting. So it turned out that by the time HCFA was supposed to submit the report to Congress on volume control there was no problem with volume to report on.

Now the Commission remembers that now the discussion is changes in hospital products, which reflects a concern in the other direction.

In the second set of elements there's an adjustment for case mix and this is really basic to the development of a payment system because when you talk about consistency of payment systems and you talk about providing incentives you want to pay an amount that reflects the type of product that's being provided. On the hospital inpatient side, the case mix measure is the DRGs, which are essentially groups of diagnoses. In the physician setting it's the HCPCS, or the individual procedures.

Along with the case mix measure, there has to be a determination of the relative weights which reflect presumably the average costliness of providing the service efficiently. In the DRGs the relative weight is based on the average cost of treating patients in each DRG. On the physician side there was no data on average cost and the analog to the relative weights, the RBRVS, was developed by building up the components of cost for each service and the pricing those services out to reflect a similar concept.

Again, Medicare+Choice involves a case mix measure, too. That's the risk adjustment. The objective there, just as it is on the provider payment side, is to have payment correspond to the expected cost of providing the service to the Medicare program on the part of the plan.

There are geographic adjustments in all of these payment systems. On the hospital inpatient side, again, it's the hospital wage index which reflects differences across geographic areas in the costs that a hospital providing a given product would be expected to face because of the prices of the inputs that they purchase in producing the product.

There's a similar concept applied, although it's developed very differently, for physicians. There are similar concepts provided for all of the prospective payment systems that I listed earlier. And in the Medicare+Choice case, again, you'll be talking about the application of this kind of decision-making tomorrow morning when Sarah does her presentation.

In addition, many of these systems have special provisions for certain types of providers or plans or areas. The hospital PPS has numerous examples of these: the sole community hospital is treated differently than other hospitals under hospital inpatient PPS. Rural referral centers were treated more differently, now are treated somewhat differently. There are some special provisions that favor referral centers. And then there are, of course, the big ones, the indirect medical education payment and the disproportionate share hospital payment under the hospital inpatient PPS.

Physician payment also has a special adjustment of this type in the HPSA bonus to recognize the fact that there are some areas that are underserved and physicians locating in those areas are more valuable to the program and require a higher payment to attract them to these areas.

There are also special payments for rural health centers and Federally qualified health centers that fall under this category. One of the major issues in the development of the hospital outpatient system is whether or not there should be special adjustments for some types of facilities.

You can apply this kind of reasoning to the Medicare+Choice, as well. The Congress implemented a floor to the payment rates in some areas, and the justification for this was that without some minimum payment rate, it would be impossible to attract Medicare+Choice plans to those areas. The blend between local and national rates, to some extent, is a reflection of this as well when it finally does take effect in the future.

Given the concern about plans withdrawing from some areas, one of the sort of implicit issues is whether the plans are withdrawing from those areas because they're not getting paid enough. Of course, there's the question of whether they would be able to adjust those products in those areas if they could.

There are two broad issues that I'll finish up with. One is setting initial payment rates. This is an issue that really is basic to the discussion of a payment system because it gets at the issue of whether payments are appropriate. It also gets at the issue of comparing payment rates across settings. The information that Ted Lewers gave out, that was pretty striking, about the different rates that are paid for services with the same name that are provided in different settings raises that issue. But the question is what criteria can we use to determine whether the payment for a particular service in a particular setting is appropriate?

One way that's commonly used in payment systems is to reflect the cost, the average cost or the desirable cost, of providing that service in that setting and then determinations have to be made about whether the existing average is the right amount. In the hospital inpatient

PPS that was what was done, subject to some budget considerations. But the main decision there that has to be made is given what costs look like, what should they look like? And that's, of course, a much more difficult issue.

The Commission will need to address, in discussing all of these systems, whether it's a consistent approach to payment in different settings or whether it's actually a consistent payment that's required to rationalize the system.

The final issue is updating the rates. Since the rates are set they have to be updated each year. Generally, the concept is that rates should be increased enough to reflect what should be the increase in the cost of efficiently providing the service from one year to the next. That's what's done in the hospital inpatient PPS.

Now the issue of a sustainable growth rate introduces another concern to the process, and that's protecting Medicare from the burgeoning costs of some types of services. Another issue the Commission is going to have to address, in discussing all this is at what level that concern gets applied? One approach is to apply a sustainable growth rate to the program across the board with individual updates for types of services that get adjusted for the total amount of projected spending. Or a few years ago ProPAC recommended the application of an expenditure cap on the combined hospital outpatient and physician spending in order to reflect the fact that you didn't want to freeze one sector at its current proportion of spending in the program when technology changes.

So as we discuss the specific payment systems, I'd like now to hand it over to you and have you discuss some of these issues. In some ways, it's a continuation of the discussion that you had this morning. Hopefully the chapter we end up with will lay out a sort of framework that describes the Commission's thinking on some of these issues.

DR. WILENSKY: Let me just remind people that there's a tremendous amount of material that we have just gone over, in terms of the structure. So your thoughts about determining payments, retrospective, prospective, negotiated, competitive, the new payment systems that are involved and are talked about, consistency and similarity and what it means to go now for the SNFs and the practice expense and ambulatory and outpatient and home health, et cetera, talking a little bit about what we've got already that we either want to make others consistent to or that we have to move along, and then the various issues that Stuart raised in terms of objectives and then some other issues.

So a tremendous amount of material and to try to, as you can, share with us some of your thoughts on each of these various areas.

MR. MacBAIN: Just a brief thought, to get back to your objectives with a payment system. That would be to add another objective at the top of the list, and that's to first do no harm. A payment system should particularly seek to avoid penalizing the decision-maker.

My context for that in light of this morning's discussion is the effects of things like different independently operated constraints on growth that might interfere with movement of beneficiaries in and out of health plans and movement of services from one location to another.

MR. SHEA: Gail, just a point on process. I assume this is not a discussion so much focused on the recent activities within Medicare+Choice? We're going to cover that in the next section, I assume?

DR. WILENSKY: Right.

MR. SHEA: Stuart, I'm just curious as to why in your objectives you didn't more explicitly state some of what I think is implicit here, that these systems be fair to providers and

adequate to consumers in the sense that they don't overly burden beneficiaries. It seemed implicit but I'm curious as to why you didn't make those explicit, or more explicit?

MR. GUTERMAN: We had a discussion about that point. The staff had a discussion of this in developing this. We batted around some issues and decided to sort of be spare in what we presented. But those objectives certainly are implicit in them, but we can mention them explicitly in the chapter.

DR. WILENSKY: Can we also mention, if we're going to do explicit, to be fair to taxpayers, too?

MR. SHEA: Good. I just think in any explication of this that we would put in a report that we would want to make sure that these sort of broad issues, including taxpayers, are referenced. If what we're doing is trying to set a construct then that would help guide work at a more and more detailed kind of level.

MS. NEWPORT: Just a couple of thoughts. I thought overall your thesis was well grounded, but I thought just maybe amplifying a couple of areas.

Under objectives, I think one of the things we should be looking at, too, is payment predictability. I think that goes to a little bit about what Bill MacBain is also saying, is that provides stability in the sector. I think that's important.

I think it's embedded in what you're saying, but I think it might benefit from talking about that a little bit, and the impact of unpredictability.

The other part of this is cross-cutting, I think, across sectors within health care. That is the cost of compliance. I'll use the example of HMOs. The cost of compliance there is cross-cutting into fee-for-service because of their contractual relationships. Sometimes the imposition of those is drilled down or drilled up, depending on how you view the system.

I think that that's part of payment that goes to -- I think you touched on it -- diversion of resources from maybe providing health care to something else that may not be as beneficiary friendly or taxpayer friendly, to pick up on that theme.

So those are just a couple of thoughts that may bear some linkage within your context here.

MS. ROSENBLATT: I just want to say, I like the basic idea of extending beyond similar payment no matter what the setting and taking it one step further and saying there are also similarities as you go from the role of provider payment to the world of Medicare+Choice. I like taking it across that very broad look.

What I'm about to say may be really simplistic for some of the clinicians in the room, but what I'm particularly interested in -- and it's probably because of my interest in risk adjustment -- is if I think of this comparison of case mix and risk adjustment and, in my simplistic way of looking at all of the case mix adjusters that we've talked about, whether it's inpatient or the outpatient we've been talking about, seem to me to be more procedure oriented. And the risk adjustment methods that have been worked on seem, to me, to be diagnosis.

Has any work been done on mapping the two? They are attempting to do the same thing. I can understand why the payment mechanism and who the payment is to has led to the different approach of procedure versus diagnosis. But it would seem to me that there might be some good of trying to get to something in common, and that that mapping might be worthwhile.

MR. GUTERMAN: That issue came up frequently in the discussions about what the appropriate case mix measure would be to use for hospital inpatient. And I'm sure in the other settings as well, but particularly hospital inpatient, because there were several alternatives

proposed. Some of them, I remember being dismissed -- at least by some people -- on the grounds that they reflected more what was done in the hospital than what the patient needed.

It's never a perfect -- I mean, you always end up relying on what's there because for one thing the patient, you know, the best way to tell that somebody needed something is they got it. But it's not perfect.

But certainly, for something like Medicare+Choice, that's part of the problem is that you want to know what the services that somebody's going to be expected to use in the future and you'd like to not have to rely on what they used in the past. But so far we haven't been able to develop methods like that.

DR. KEMPER: I think you did a nice job pulling together how the payment rates are currently set and abstracting the common elements, particularly at the end where you were talking about the various stages and in setting the rates, and talking about the need for a constant set of principles.

There's one set of -- I guess they're principles that I think it would be useful to discuss in actually implementing that in particular cases. That is to do with, in setting a payment rate, what's the criterion if it's system-wide efficiency? Is it incremental cost? If it's incremental cost, what happens if incremental cost doesn't cover average cost? Is it incremental cost of the efficient provider or is it, as a practical matter, just the cost that's out there?

And if another criterion is consistency of payment across settings, what happens when those principles conflict? I think there's a second level of principles that it would be useful to articulate in order to implement the various stages along the way.

MR. GUTERMAN: We could use the input of the Commission on those two issues. I think those are very important issues. We'll start with the first one. The question here, on

the hospital inpatient PPS there was a lot of discussion and HCFA spent a lot of time and other people have spent a lot of time thinking about what the efficient facility is. It's very difficult to identify that and it's very difficult to identify what the costs should be, because that's sort of the notion that's reflected, what the costs should be.

So HCFA sort of took the default and used the average. And some version of that has been applied in a lot of the payment systems that exist now.

The discussion this morning on the outpatient side, and part of the discussion of the differences in payment rates across settings, has to do with the fact that all of these payment rates have been developed in one way or another or are still directly based on the average cost of providing the service in those settings.

I guess the thing that occurred to me while you were having your discussion this morning about the outpatient services was that the current systems -- these aren't new services. They've been provided for years. The Commission has been worried about sort of the incentives that would be put in place if rates were very different across settings for services that had the same name.

But in fact, the current payment systems already provide these -- in fact, in many cases, the current payments for services in different settings differ even more than the proposed prospectively set rates because there are some adjustments sort of implicitly made or explicitly made and the way those rates are set. We don't seem to see -- or in some cases we do seem to see the kinds of reactions to bad incentives that you're worried about.

The question is, I guess, do you start from the cost of the service? And then again, yes, is it average cost or marginal cost? And if it's marginal cost how do you account for the sort of fixed part of the cost? That's an issue that Joe raised.

For purposes of this chapter, and also in general for the discussion of all of these payment systems, I'd like to hear what the Commissioners have to say on this issue.

DR. KEMPER: I guess the other thing that I think would be useful to discuss in this context, in this sense of general principles, is what signals we look for, what kinds of things to monitor to determine when there are errors in the rates. It seems to me it's much easier to identify signals when the rates are too low rather than for when they're too high.

But it seems to me that's something that would be useful to discuss in this sort of general principle, of what kinds of things do you look at to see whether when you try to implement these principles you've made mistakes.

I guess the third comment I had, and this is a more minor comment, you mentioned that the chapter would draw a lot from the hospital prospective payment. I thought your comment in the presentation here about the importance of the nature of the service was a really good one. I think there's some risk of taking the hospital experience, which generally is viewed as a success, which has a whole set of particular service specific qualities to it that allow it to be a success, and then taking that thinking and extending it to other kinds of services -- like some of the subacute, for example -- where some of the quality assurance tools and so on aren't in place.

It could be misleading if you focused primarily on the hospital.

DR. WILENSKY: Can I just ask to clarify something that Peter had raised? You may have responded to it, but I wasn't sure I understood.

This issue, in terms of looking at costs, of looking at the average cost of what exists as opposed to what an efficiently organized system might look like, which is an issue we really trip on it seems to me in a lot of the discussion that we have. We were doing it this morning in outpatient. One of it was trying to figure out what the average cost was and whether or not there

were things in the average cost that reflected how costs were allocated between inpatient and outpatient.

But there was also the issue implicitly, which we never talked much about, which is whether we wanted to pay for them anyway. Is this something that you would see being discussed in this type of a chapter?

MR. GUTERMAN: I think the concept would, yes. There's a simple model, a simple concept that I use. If you look at the components of actual cost, you've got sort of the difference between -- you've got the component of actual cost that consists of sort of allocated overhead and other kinds of facility specific factors, some of which you want to recognize, some of which you don't want to recognize, some of which you want to recognize but maybe would be better recognized through another means.

And then you've got the difference between the actual costs and the efficient cost, which may be a totally different consideration.

I think how you approach the issue and what kind of process you go through to determine what costs should be, at least as far as how they should be reflected in the price you pay, I think yes, we were going to discuss that in this chapter.

DR. NEWHOUSE: I actually didn't realize this was going to be a chapter. So this started out as a response to, I think Alice and maybe Janet. But I think it gains more force if it's going to be a chapter.

There's a substantial amount of economics literature on procurement and contracting. These are comments about the use of procedure in payment.

One of the things the literature talks about is whether a contract is low powered or high powered. And by that, it refers to the incentives of what I'll call the supplier or the provider to

keep down costs. So the extreme example of a low powered contract is a cost plus fixed fee contract. The extreme example of a high powered contract is a fixed price contract. Then there's obvious gradations in the middle, various kinds of incentive contracts.

One of the results out of this literature is that you used a higher powered contract or a fixed price contract the better you can specify the product. So we tend to contract for things like pencils or Army uniforms with fixed price contracts. We bid it out and take the lowest bidder. And we think we can monitor what the bidder or the supplier is delivering.

We tend to use the low powered contracts like cost plus fixed fee when we can't specify the product very well in advance. So the typical place where we would use that would be contracting for research.

In the context of our payment systems the Medicare+Choice system is a high powered contract. It's a fixed amount of dollars. The hospital prospective payment system is actually a considerably lower powered system, both because a lot of the DRGs are defined on procedure, and because of the outlier payment system.

For those of you, and I know there are some of you around the table who think that everything should be very high powered, think about the hospital payment system in the context of no procedures there. In other words, I'm saying I think there's a good reason why the procedures are there. Think about payment for heart attacks, which in the current case varies by whether or not you have a cath, whether or not you have a CABG. If we paid the same amount for everybody with a heart attack, we presumably would not have very many hospitals with cath units and there would be an issue about were we underproviding. Because in effect the entire expense of the unit would come from the hospital's bottom line in a fully high powered world.

Another way this relates to the comment Stuart just made, and to tie it back to my example of pencils versus research and contracting, the hospital admission is probably the place where we can best define the product and monitor it relative to many of these other systems because there's a fair amount, I think, of consensus -- not complete by any means -- on what services ought to be delivered in an admission to a patient with a given diagnosis.

And the contract where I think there's probably the least consensus or agreement is in the subacute area that Peter was bringing up. How many home health visits a person somehow should have, I don't think is brought up in any medical textbook I've seen, nor have I ever seen any guidelines on it.

Therefore, the inference I would draw would be that probably in those areas we ought to have lower powered payment systems. In fact, that's what we have. We have payment per visit in the home health area, for example.

This might be a way for you, Stuart, to bring up a discussion -- or I would suggest, actually, that the chapter ought to have a discussion of this kind of thing, and it could reference the economics literature on this point. But I think most of it is fairly apparent and doesn't require a lot of jargon to get through.

MR. GUTERMAN: In response to that, another way of considering it occurs to me that sort of naturally opposes that and that's on the home health front. There are two considerations on home health that could lead you to go in the other direction, and I don't know that -- you know, over time I guess we could put it into a more structured framework.

But one is, if you have a type of service that you're willing to devote a certain percentage of your budget to because it's amorphous, so you're going to say, I'm willing to spend up to a certain amount on this because I know that some of it is necessary, but I can't define how

much of it is necessary, and I know that the current situation has distorted decision-making in that area so much that I can't use existing data to evaluate that.

And another is sort of analogous, that if -- mention has been made of the practice expense component of physician payment, that the feeling was that physician fees had distorted the distribution of both physicians and their services in such a way that existing fees couldn't be used to represent what the price of the service should be. That's, I think, one of the reasons that you have wanted to build from the bottom up.

DR. NEWHOUSE: My comments were going more to basis of payment than your typology. That is, I could decide on the principle that I wanted to spend X percent or X dollars on home health and I could divide that up per episode, however I would define that, or per visit or per some immediate thing per month.

DR. ROSS: Just a quick follow-up on that. I guess I thought you were heading towards some sort of partially powered system.

DR. NEWHOUSE: How did you guess?

DR. CURRERI: It was very subtle.

[Laughter.]

DR. ROSS: But I guess more seriously, you're suggesting that the literature suggests that the cost-plus framework we've been in with subacute is actually in some sense optimal?

DR. NEWHOUSE: No, it just suggests that the less well you can specify before the fact what you want, and the less well you can monitor the product, the low powered the reimbursements or the contracting or the procurement, however you want to term it, the payment system, ought to be. That's all.

DR. ROSS: Ought, from whose perspective on this?

DR. NEWHOUSE: From the government or the payer in terms of how the supplier system or provider system will respond to the payment systems you put out there, in terms of what the government is trying to accomplish, or as measured kind of by conventional economics really criteria of social welfare.

DR. ROSS: That gets to an important question of what is trying to be accomplished there in terms of --

DR. NEWHOUSE: Yes.

DR. KEMPER: But I think part of the problem, isn't it, Joe, that in the contracting world we think about the payer and the consumer of the product being the same person.

DR. ROSS: One and the same, yes.

DR. KEMPER: And there being an ongoing exchange of information about the product in the cases of the soft contracts. So that if you're contracting for professional services, the person who's using it is also the person who's paying for it, and as the project goes along there's a negotiation. Here we have a separation of payer from the consumer and the consumer has no incentive to carry on that negotiation.

DR. NEWHOUSE: That's true, but I'm not sure it changes any of this logic. I mean, the government in this case is acting as an agent for the beneficiary. Now the beneficiary has his or her own set of incentives that may distort things, but these are the incentives that the government is trying to provide to the providers or suppliers.

DR. WILENSKY: I think it correctly defines what is or does occur. I guess I'm less clear about the optimality of it.

DR. KEMPER: I think the missing piece is the government's coming back and negotiating or monitoring the quantities side of it, and that's what I think makes it hard on some of the low-powered contract side is where the limitations on the use, how do you come back on that side of the contract.

Maybe that's the way to think about it is, for example, on the home health, what is the nature of -- at least where it takes me is, what is the nature of trying to get closer to the hospital world where there are some guidelines about what's a reasonable amount of service and under what circumstances. So you push on that side to use the low-powered contract. But it requires some other kinds of mechanisms.

DR. ROSS: Just to follow up on this. With the beneficiaries, that also means there's a second dimension here in terms of the contract. There's also the cost-sharing contract that's involved.

DR. LAVE: I wanted to make a couple of -- again, I think we're in the broad, overview statement. On the first page, where you have alternative process in determining payments, one could always put charges in there because it is an option that in a competitive market in fact one would use and you may want to put it up to deny it, because we have other things in here which we're not using and so we're bypassing them very rapidly. So it does seem to me that that is there.

MR. GUTERMAN: I guess I consider charges part of retrospective cost base because it depends on --

DR. LAVE: They're different. No, they're a very different concept because in one case you go through and you do it.

I guess the second issue is that I think that there may be a lot of -- that I think that we should indicate that one could negotiate the rates in competitive rates and there are lots that can be said in the favor of doing them. But this is not about that, so I think we want to go by it.

MR. GUTERMAN: Yes.

DR. LAVE: So I just was reacting to Gail's view.

In terms of the overview then, it seemed to me that -- I want to talk about the efficiency issue. I don't know how many of you ever have done any Boren Amendment cases where you were trying to worry about the most efficient hospital.

Let me tell you, it is a very difficult thing to do and I'm not really sure, having done one of those cases and having somebody talk about taking the 10th percentile of actual costs as being a reasonable version of efficiency that that's necessarily -- I mean, as an economist I have to like it. But I haven't seen it play out in practice. I think that there are issues that are...

DR. KEMPER: But I think if you know that that's your principle then at least it leads you to think about, oh, that's a component of inefficiency here that I wouldn't want to allow, for example.

DR. LAVE: Right. But you often don't know.

The second question that it seemed to me was that one of the things that it strikes me as we've talked about what's happening as we move to prospective payment system, and I sort of alluded to this earlier, is that the implicit becomes explicit. I think that that makes a big difference in how you think about things. When we move into the prospective payment system for hospitals, all of a sudden the graduate medical education stuff which nobody ever really talked about, became very explicit in terms of what we were doing.

As we move from retrospective cost-based ambulatory care systems to thinking about a prospective payment system for outpatient services, all of a sudden things which were implicit before -- we never thought about how much did it cost to do an x-ray in a hospital, how much do we pay for this in the hospital. This now becomes very explicit, and I think it causes us to think about things very differently, and it ought to be recognized. Because I think it changes our mind-set and also changes the mind-set about how you're going to move future in prospective payment system.

The third thing it struck me, and I think this is a little bit related to the high-powered, low-powered, just sort of conceptually how well can you define an episode? That's another difference between the unit of payment. But we focus on the hospital because the hospital is an episode with somewhat of a beginning and an end, and care is taken, and the government doesn't really want to get into the mish-mash of what's going on. But if you think about an outpatient visit, it's just very difficult to try to think about what an episode is there.

So that's partly this high-powered, low-powered. But I think it's also useful because it gets to the home health. Can we think of a home health episode? I think we're all struggling to think about what a home health episode would be. So this is back to the unit of payment but takes maybe another little twist on it.

Then the final thing that I would say is that it seems to me that we have to recognize that we're developing this administrative payment system which is going on its own route. The question is, should we ever come back and look at what our administrative system is doing in different areas of the country compared to what the other payers are doing, and should we be concerned about that?

Now we do that periodically with physician visits, but I mean, the government in some places is a terrific payer; in some places it's a dreadful payer. Would you want to know that in terms of fine-tuning the system in terms of the wage adjuster that we used.

So it's just a question of, do you want to come back and approach reality -- Medicare pays on average X thousand dollars for a bypass procedure including all the physician components put in, the average HMO pays Y. Do we care about that and does that then provide us information maybe that can be used in fine-tuning what in fact we are doing? I just think we may want to have a real world base, particularly in those areas where Medicare is either a -- is a small payer.

MR. GUTERMAN: We have that at the hospital level from the AHA data that we analyzed.

DR. LAVE: We're moving more and more and more in that direction.

DR. WILENSKY: I think it gets back to the issue that Joe had raised with, on the cases where you can define an entity, a product well, like a particular high cost or high volume procedure, then it is much easier to define what it is you think you would like to pay or should pay, as opposed to a more amorphous occurrence where you either have trouble because you don't know what the product or service is exactly that you're buying, like a lot of home care has turned out to be, or some other admissions where it's not as defined and therefore not as easy to wrap as a package.

But are you thinking about this as an early chapter would be an umbrella for the issues that come up?

MR. GUTERMAN: Yes. The Commission raised the issue of the silo effect. In looking at the original outline of the March report what we intended was for the first chapter to pull

the concepts together, and then, because these systems exist separately, we have to address them separately. But the report would begin with a statement of the Commission's notion of how to approach these systems and what the connections are.

DR. LONG: Another spin on this. This relates obviously in part to issues of predictability vis-a-vis stability in the industry and relates also to the difficulty of trying to figure out what we mean by efficient. But to what extent do the things we think about in setting and updating rates provide room and degrees of freedom for innovation and change that maybe none of us have thought about?

You look back over recent history in the program and you see some things that are put in there to -- that seemed to create a judgment that there ought to be geographic homogeneity nationwide. And there are other things that are put in there when you move away from national rates and you start adjusting for difference in local labor markets. So some things you'd say, okay, differences are fine and other things, differences aren't fine.

Sometimes we make it real easy to have entry into the industry, and then we turn around and start protecting the people who are already there and make it more difficult for new entry. We talked this morning about, you buy the physician practice, Mr. Hospital, and then you hang the outpatient department sign on it or not. Some things we like, some things we don't like, but it seems to me in anything this complex where you can't really predict precisely what it is that you're buying or what's the most efficient way to do it.

We have to decide how much we might be willing to devote in the short run to inefficient payment that allows degrees of freedom for change and innovation and restructuring and reorganizing as opposed to building a system that guarantees that tomorrow will look like yesterday

because, by God, that's what we pay for, and if that's what you pay for, that's what you're going to get.

MR. JOHNSON: I guess my response is I'm just totally bummed out. The fact is we talk about simplicity and we talk about trying to include more under categories. I don't know whether it's the silo effect or the fact that we're trapped by what's going on in the BBA, but other than the Medicare+ side, you got the idea that there's a payment for beneficiary and then it gets worked out downstream.

We seem to be, if anything, more micromanagement oriented in terms of more individualized silo payment systems, and that carries me back to some of the discussions we tried to have about a year ago which is, if we could step back from this a little bit and decide how to rationalize some of this. It seems to me we're getting further from rationalizing it and more into dissecting it and dividing it and then trying to take those little divisions or little silos and then trying to rationalize those, set them up, and then come back out and try to go to the next silo.

I guess I just feel a little bit overwhelmed on direction here in terms of, when you try to talk about putting this whole chapter together, it becomes a contradiction.

DR. WILENSKY: I think the point of what we are trying to do here is to amplify on the issue that we've raised now in the last year's report and this year's report which is that in the minutiae of which we, by statute, need to involve ourselves; that is, commenting on the payments for each of the separate payments as they are written into law, which we do and will continue to do, we are being struck by the fact that we are paying different ways for what may be either precisely the same service or an overlappingly similar service which when provided in one site gets paid in one way and another site gets paid in another way, and that that will have undesirable incentives either in terms of access or quality or efficiency or cost, or all of them.

But in order to make that, first to make the claim, you need to be able to demonstrate that indeed you are paying differently for what are similar services. Second, you need to take a step back and to realize that in the differentiation that exists in law, some of the same questions are answered, they're just answered in very different ways.

So if you focus on what question were you trying to answer when you set up an outpatient PPS, or a home care PPS that was either different from or similar to what you were trying to do when you set up an inpatient, or what you did when you set up something about physician payment, maybe we can begin this series of steps to try to think about what consistent payment systems would look like, or to recognize that sometimes we may want to have differences because there's something about the nature of the payment or about some other objective that we can't make them the same, and then we recognize that.

So I think it is an attempt to be more explicit about where we've gone. The fact is, what you're reflecting I think is the reality of what the statute has done.

DR. ROSS: I just wanted to take a similar kind of theme. One is, in the short run we're doing this because we have to. But to look at the longer run, we need to think about how we got here. The notion here is to try and provide an overarching kind of infrastructure for commissioners to think about and realize that this very disparate, so-called silo system we have now didn't entirely arise by accident. That there's a lot of considerations that led into things developing the way they did.

DR. WILENSKY: But if anything, we're moving against what we had suggested as our desirable direction last spring. It's not that we don't recognize it. What we're trying to do is first

to be responsive to HCFA or the Congress, which has suggested or are least welcomes our weighing in on the regulations that are put out in response to statute.

But at the same time, to indicate when, as I think we felt this morning in outpatient PPS, this is going exactly against what we were suggesting in terms of trying to bring the worlds of physician payment and outpatient, and we think that is more likely to be similar than some of the inpatient-outpatient, and that it concerns us that we have these very different modes of payment.

But it doesn't really absolve us from saying, if you're going to do it, watch out for some things and don't get into other things or, if you want to do that, do some things because it will mess up less. It doesn't relieve us from the responsibility of commenting and trying to help do what was directed in statute.

MR. JOHNSON: I just wanted to make sure that as we got into this overview discussion that we weren't attempting to rationalize where we found ourselves, but we were trying to --

DR. WILENSKY: No, actually quite the opposite. I think definitely to not be stuck into that.

MR. GUTERMAN: The way I look at it is, that if you want to build a structure that unites all these silos, that the first thing you have to do is look at the structure of each of the silos and figure out a way that you can put them together in a rational way where the new structure will stand up, rather than to just get bulldozers and push them all together in the same spot physically. You have to really look at the underlying structure of each of the silos and understand them, and understand how they're the same and how they're different before you make decisions about how you combine them into one structure.

DR. LAVE: I wonder whether or not that might be something that ought to be said in the overview, that if you talk about this that you may want to think about them broader? Because I want to come back to something --

DR. NEWHOUSE: What ought to be said?

DR. LAVE: He just made a mention that maybe one of the reasons we'd want to rationalize each of these silos and making sure that the payment systems are consistent, that we could then bring them together again. It would easier to bring them together again if we started defining things, you know, if we had the same terms for outpatient -- people who were in an outpatient setting.

I guess I also wanted to say that, and I think this follows up on what Spence said, is that you may want to comment or we may want to comment that there are probably areas where we could think about moving things together, like treatments of heart attacks, treatments of breast cancer, where you think about bringing a hospital and the physician component together for some of the hospitalized procedures that tend to have a consistent set of therapy following it, like hip replacements, that we may think about turning into broader episodes.

So I think that the way that the discussion is is sort of all these little pots. It might be nice if there was someplace that reflected on the fact that for much of this we might think, not for everything, but for some big things that we might be able to think in terms of bringing things back together again in order to think about things better.

And one of the things that might actually be helping that a little bit is -- because my sense is, and I may be wrong about this, but that the physicians practices and the hospitals are becoming closer sort of tied together, that might facilitate some of these things now that in fact would have been harder to do 20 or 30 years, 10 years ago.

DR. KEMPER: I just wanted to agree with Hugh's comment about technological change and suggest it might be included as one of the goals to encourage both cost saving and quality enhancing technological change.

The other question I had was, you didn't say much about updating in your written document. Do you plan to expand this to include principles, sort of long run balance?

MR. GUTERMAN: Yes.

DR. KEMPER: Because Bill MacBain's point earlier this morning about the caps on different silos, if there's anything that would lead to discouraging innovation, at least in a broad sense, that would be --

MR. GUTERMAN: The Commission at its retreat, you raised the point of looking at different approaches to updating, and I was thinking at least that would be reflected here.

DR. KEMPER: Both the overall aggregate and the payment specific?

MR. GUTERMAN: Yes.

MR. MacBAIN: I can't resist returning Joe and Murray's high lobs on partially-powered contracts. I think there is an interesting direction there. Joe was alluding to this earlier this morning when we were talking about what happens if you get a consistent approach to paying for things, recognizing that you can do the same things in a doctor's office or an ambulatory surgical center or a hospital and the cost will be different.

Particularly when you look at the hospital, one of the reasons the costs are different is because it costs more money to run a hospital overall, and the accountants will allocate some of those costs to the outpatient department. And the more you do on an outpatient basis, the more those costs will migrate to the outpatient area. You don't even have to finagle your cost reports to do that.

If you don't recognize that in the payment system, you get a more rational payment system, but then you're doing some damage to the hospitals' ability to do all the things that we want a hospital to do.

An alternative is then to find another way to support that. Now that's got some positives in the sense that it takes it out of this discussion of how we pay for discrete services and let's us get more uniform. And there are some hazards there, but it at least let's us look the same, develop some neutrality across settings without doing damage to the hospital.

The negatives are, you begin moving things from an entitlement payment and putting it in an appropriation payment, where it changes the political dynamic considerably. So it's not something to recommend without some thought, but it's the kind of thing I think we ought to look at when taking a look at overall payments.

If step one is to say, here's what we've got right now and here's where we see things that are likely to happen. If step two is to suggest, here's why we don't like that and why we think we shouldn't be going that direction.

Step three then ought to be, here's some alternatives that can rationalize the things that can be rationalized and address directly things like maintaining access to a core of hospital-type services in a rural community, or maintaining a teaching hospital's ability to carry out biomedical research or whatever.

Another thing, and it's sort of related to that and this again got back to this mix of high and low-powered contracts, got me thinking about the HMO experience I had with primary care capitation. A little simpler model, easier to deal with. But if you're paying a per capita payment to a primary care physician, that's a high-powered contract. It's a fixed price. You're assuming all patients are the same. At most you may vary it by age and sex.

But in this case, in addition to paying a primary care capitation they're also paying a fee-for-service payment for immunizations; recognizing that immunizations are something that the health plan wanted the doctor to do and one way to encourage that is to pay for it. It was an interesting fee schedule. The fees represented -- it was cost-plus where the cost was determined by the health plan, because they'd been able to negotiate a contract with the supplier of immunological agents. The doctor would buy the agents directly from the supplier under the health plan's contract.

So even though it was a low-powered contract, you've got the health plan actually having control over the way the costs are incurred. The variable there was frequency, and it's for a service where a high frequency was a good thing. Just as Joe was talking I started thinking, now there are ways to mix these so that you get the best of both depending on what you want.

DR. NEWHOUSE: But I think you can have these payments without getting to the financing side. That is, I think you can do it within the entitlement. The example I'd give you would be the direct med ed payment, which is basically a pass-through but is still on the Part A side.

DR. WILENSKY: There was a point Judy made about the movement to a more explicit, and when you made the point about some of the areas that if you were to take it out, whether you do it in an entitlement or an appropriation, I think a lot of what these issues are raising now is as a result of moving to more explicit payments.

It's clearly, to my mind, the pressure to equalize the capitation rates across the country was a reflection of what, as we know, was going on for many years in Medicare. That is, how much was being spent on seniors varied enormously within an age, sex category depending on the geography. But it was when we made that payment explicit in the form of a capitation rate that it was really very hard to ignore.

A lot of what I think is happening, that as we get more explicit, we are pressed to make decisions that make the pricing more explicit, it's hard to ignore these peculiarities that are part of the system. Therefore, we're pressured to rationalize them, or explain them, or remove them, or to do something else, and that that really may also be, at least in some part of the background of this discussion of what is going on, because I think it's going to continue to move down that track.

This will be very interesting. I'm sure we will have many comments when we see what the draft of the chapter actually looks like. Does anyone else want to comment on this?

MR. MacBAIN: Just a thought, and maybe we can do this after we see a draft. We ought to think about, do we really want this to be a chapter in that sense or is this something that we want to sort of weave through elsewhere. Because I think this started out as kind of, let's get ourselves grounded on where we want to go. Maybe it should be. I'm not presupposing one way or another, but I'm not sure that we want to just jump into it and say this ought to be a chapter on its own. Or whether it ought to be in the March or the June report.

DR. WILENSKY: I think this is an important piece. I suspect we're going to want to do something with it once we go through all of the pain of actually having to say what it will ultimately say. But whether to have it as a freestanding piece as a chapter in the March report or the June report, we can certainly make that decision when we have it.

DR. ROSS: I would hope our decision won't be based on sunk costs here. But I think having a chapter that gives a set of organizing principles and, again, infrastructure to guide will be very helpful to the commissioners and to the Congress to think about this kind of stuff. So my vote is for a chapter.

MR. GUTERMAN: And the points raised in that chapter can be woven through the succeeding chapters as the specific issues are raised.

DR. WILENSKY: Thank you, Stuart.

Before we go to Scott, if there's any public comment about the issues that we have dealt with this afternoon? [No response.]

DR. WILENSKY: Okay, Scott?

MR. HARRISON: I'm going to talk briefly about the Medicare+Choice payment section of the March report, and you'll see in Tab D it has an outline of the chapter. Then we'll get into a bigger picture -- although a little smaller than Stuart's picture -- discussion of payment adequacy for Medicare+Choice plans.

The slide here describes what the section on Medicare+Choice payment system would look like. First we'd have a review of the system, look at the formulas and their history, look at the goals that Congress had in BBA and maybe see how they were being met or not, and go over past recommendations. Then we would go into -- we anticipate doing a big picture look at payment adequacy, and for the purpose of today's session I'm going to discuss that last. Then we would have an examination of the specific technical improvements and recommendations that the Commission would have.

The Commission has made recommendations in most of these areas last year. I'm just going to very briefly mention these areas, but you're only going to hear about one of them in this set of meetings tomorrow when Sarah presents the price variation.

Last month you were briefed by Julian and Dan on HCFA's risk adjustment plans and we plan on looking at them. And as I said, tomorrow Sarah is going to present work moving towards recommendations on geographic price indices.

Tom Kornfield has begun working on the issue of whether counties are the best areas to use when setting payment rates. You're going to see a presentation on this issue in December or January. I want to note that this issue, while it's related to the presentation by Tom that you're going to see following this one, that it is slightly different. It's really going to be focusing on the payment areas and different possibilities you might have.

At one of the upcoming meetings Jack Ashby is going to present a workplan for dealing with the VA-DOD adjustment that you recommended last year, the issue being that not all of the costs for the Medicare population were measured in the AAPCC because some of the Medicare population used VA-DOD services.

Then finally, last year there was a recommendation to carve out the disproportionate share adjustment and Jack Ashby will also be working on that.

Before I get into payment adequacy I wanted to know whether there's any other specific issues you think should be addressed in this chapter.

DR. CURRERI: I'd like to ask one question that's beginning to concern me, and that is, how do we decide when the lack of participation in a Medicare+Choice plan becomes such that it shouldn't be continued because of inefficiencies or inability to collect data? I feel that maybe medical savings accounts and/or PHAs just may not have any participants, and I didn't see anywhere in there that you tackled this. It seems to me it's something we ought to look at before we get there, and I just wondered what your thoughts were.

MR. HARRISON: I think that could come up as an issue in payment adequacy. Are we paying enough for a service? And if not, do we care, because maybe it's not efficient? And how do we go about looking at payment adequacy? So we would be moving into that next.

DR. CURRERI: I don't think it's payment. I think that there's a possibility of non-participation becauase the risk is very high, in the case of medical savings accounts, let's say. Or I think there may be a lack of participation because no PHAs can get by state regulations or satisfy the capital requirements, or something much different that just purely payment issues.

But I think somewhere along the line we need to think about when the lack of participation just simply creates itself an inefficient system, because I think that's a potential. I don't know what adequate participation is, but I know no participation doesn't make sense. I don't know how much you have to have to make it efficient, but somewhere -- I think in this chapter we need to look at that because it obviously will take a change in law to get rid of any of these choices, but that may be necessary.

MS. ROSENBLATT: I'm going back to answering the question about what else should be on the list. I just might add -- and I'm trying to categorize it -- a category of maybe administrative issues. Because it seems to me that the plans have brought up the timing, maybe an issue of when they need to file. So there could just be issues like that of the administrative workings of the system.

MR. MacBAIN: I'd maybe go a little bit broader than that; the whole regulatory climate. It seems as though, in addition to the payment arrangements changing, a lot of the other rules are changed. Some of those are in the BBA and some of them are in HCFA's interpretation of the BBA. And what has always been a fairly complex contractual relationship, at least as I look at it now, has become a lot more complex.

DR. KEMPER: Am I right to assume that the payment areas will include boundary problems?

MR. HARRISON: Yes.

MS. NEWPORT: I think you do need to slice this maybe a little differently on some things. I'd talk about the regulatory complexity. I think that there were expectations which could be termed amplified expectations of the amount of choice that was really going to be available. The simple idea of raising payments in certain areas I've always said was not the sole reason there wasn't managed care or an MSA or something else there. It had to do with the provider system itself and the availability of providers in that area.

So I think there's -- I don't know what this falls into: unintended consequences or unmet expectations. Were the expectations real to begin with? I think that that's part of this. Part of it also is there has been a lot of certainty in managed care for about 13 years. We could argue whether people agree with whether that certainty is good or bad.

I think the fact is that those that were in the system pretty much understood it, notwithstanding some concerns going forward. I think that has really gone out the window right now, and I think that you see huge dislocations, not only in management's thought processes but also in the availability of options. For example, HCFA was predicting 500 and 600 new applications for PSOs or whatever and there is, in reality, three.

So I think it's timing. It's how you stage this. It's how much you're trying to jam into an 18-month period of time. I think there's a lot of things that -- we're trying to measure something that we haven't even really started in real terms. Timing is everything in this, and I think there's some difficulty there. So I think I have lots of ideas about things that are particularly troublesome in this area, but I think we also need to be real about what we're even going to be able to measure in the next year in terms of impact. That's just a ramble.

DR. NEWHOUSE: This is really a question for Alice or Janet probably, but both of you have talked about the need for a plan to have predictability. There's a couple issues I've never

fully understood which is, predictability is clearly relative because one of the things you don't know is what your enrollment and disenrollment is going to be. While you'll get more or less money depending on the number of people, costs will be importantly affected by who those people are. So that even under the old system things were not perfectly predictable.

Then the second thing that wasn't predictable, of course, was what was going to happen. I mean, that's the whole nature -- to the enrollees. That was the whole nature of that risk. If you had a flu epidemic or you didn't have a flu epidemic, that wasn't predictable. That has always kind of puzzled me, because I thought what a plan would care more about than predictability of its revenues would be predictability of its profit stream. And if the reimbursement varied with the cost, then that would seem to make the profit stream more predictable, and that ought to be a plus.

So I'm wondering, the issue is what kind of predictability are we focusing on here, and why?

MS. NEWPORT: I'll try to answer that. That's a good question. I think that what -- and this is just my view from my company, is that you can make it more predictable through your contracting arrangements. You can take your unpredictability down to a fairly comfortable range. Otherwise, as a company, you would get out of the business.

So under, let's call it the old system, you pretty much understood what the payment rate was. You understood over time what was an attractive product or benefit package for the enrollee. You knew how to measure your disenrollee rate over time in terms of what was normal versus an abnormal rate.

You also had the ability to, at several junctures, make improvements in your benefit package to stabilize your enrollment growth. And you could go into certain areas or expand

off a core area into a more risky area by using, say an urban area to stabilize your whole system, your delivery system.

But it's very, very complex, and I think that's the driver in terms of people's misunderstanding of what this is. They try to make it very simple, and there's lots of things that over time you were able to build up, first starting with a smaller enrollment base. Then you knew what would work and what wouldn't work in your particular geographic area. And I think you were able to shelter yourself from the real instability and the real surprises in the markets.

DR. WILENSKY: I think we need to be careful that we don't take what are important observations of what has happened now and generalize them too much. I forgot which of you earlier had raised the issue of administrative matters.

The fact is, the plans who have come to talk to me, which have been certainly not all but more than a few, have suggested that a combination of being able to come in in July or sometime other than May, which is a particularly bad time for plans. It takes a second quarter until they seem to have an adequate sense of where they are in the year.

And probably also to get off, what had been in my view, a misguided notion that you had either zero premiums or traditional Medigap as opposed to having a viable market that was somewhere in between, and the expansion in a number of areas which occurred rapidly and probably in some cases in two shallow a way, combined to produce, with a rigidity that the administrative agency applied, which is, sorry, May was your deadline and there's nothing that will do after that, may have produced shocks to the system that are not reflective of the broader issues that are part of BBA.

Now I don't mean that to minimize what is going on, or to minimize the importance in terms of what we do our next session in terms of monitoring, but I do think that we have to be a

little careful not to generalize too much about what may have been a peculiar set of circumstances that occurred because of timing problems and initiation problems that are not necessarily a part of the program, the inherent program that was set up, or in terms of what, with some adjustment in the administrative process, would reflect the program that was set up.

So I'm really not minimizing the problems of instability in terms of revenue, although I think Joe's comment about profit is probably even more important. But what we had was a very unfortunate convergence of events that occurred and then a very rigid, in my mind, rigid response to those without really thinking about who might get affected by this, or does it matter that the expectations that were included in the BBA are not going to be fulfilled in the short term?

Because the fact is, it isn't just how many people don't have access, but as I looked at -- I was just looking at this for something else. As I looked at CBO projections, it's not a question that we might lose only 10 percent of the population. The fact is, there was a pretty dramatic growth that was never being disrupted in the projections. So there clearly was something -- something happened that wasn't anticipated, and rather than try to respond to what happened it seemed that there was a very rigid position.

Now it may be that that was, when all was said and done, the only thing that could be done if you were going to get the information out, or if you were to follow the statute, or whatever. But I think we have to be careful when we set up a workplan for the future that we not get too hung up on what was an unfortunate convergence of events.

MS. NEWPORT: I hope I wasn't leaving the impression that that's what I was talking about, because I think I was answering Joe's question which was pre-May 1 as opposed to -- and I think you're right on, Gail, on talking about a convergence of things that came together this particular year.

I think that from May 1 on there was that moment in time where we had some issues that can be addressed, but I don't think that is -- those are procedural problems that can be addressed but not necessarily go to the issues that might be longer standing which is the payment adequacy issue that's been raised as part of this chapter.

So if I left that impression, I wasn't going there. I was trying to be more specific to what I thought I heard Joe saying.

MS. ROSENBLATT: I'll just add to what's been said because, Joe, I would respond to your question and say it is predictability of profits. And if I put my actuarial hat on I would say the more that I as the actuary doing the pricing believe that the plan I'm working for, consulting to, controls the fee, what's going into my price -- I mean, if I have a 10-year negotiated contract with providers that they're going to take $71 per member per month for the next 10 years and never be able to increase it, I'm going to be real comfortable putting a price out there and being able to predict my bottom line from that.

If I have a six-month contract and I've got the uncertainty of what's the provider going to do to me six months out, then I'm going to take a guess at what's going to happen to me six months out, but I'm adding uncertainty. Then the more uncertainty I add, if I'm pricing adequately as an actuary, the more margin for uncertainty I'm going to build into the price to make sure that I get the expected return or more. So that's sort of the actuarial prospective.

But I also want to absolutely agree with what Gail said. I do think that there's a lot of stuff happening at once right now and that we shouldn't draw long range conclusions. I think there's a lot of stuff happening at once, if you think just about the world of Medicare. There's also a lot of stuff happening in the commercial environment. So a lot of health plans are going through

what might be called an underwriting cycle, the bad part of the underwriting cycle that hasn't happened in six years. So there's no cushion there to deal with some of the Medicare problems.

So all of these things are happening at once. You've got year 2000. I think that the reason a lot of plans have not signed on to offer Medicare+Choice is as simple as year 2000. There's only so much you can do at once within your company.

So my advice -- and I might be getting into the next chapter about monitoring -- is a very strong plea for let's not do anything right now. Let's give it time because we are undergoing some very strange things that are all happening at once.

DR. LEWERS: I've been sitting through a couple sessions trying to figure out how to say this and I can't, and maybe I'll say it bluntly. It's, welcome to the club.

[Laughter.]

DR. LEWERS: I mean, physicians have been saying this for years and years and years and it now has hit the deep pocket. And I'm sorry, but welcome to the club. We've been talking about that. We've been talking about cutting to the quick. I don't know how else to say it.

But the physicians are still there delivering care to those patients. And they are patients. They're not beneficiaries. And I think that we forgot that somewhere along the lines. Somebody did. But the physicians are still there, and in some instances, not being paid, not at this point in time. And patients left without their physicians. Patients left having to change physicians for years because of what's occurring.

We're here for the beneficiaries. We're here for the patients, and I think that's been forgotten. I'm sorry, I just have to say I do not -- I understand the profit motive. Believe me, I understand the profit motive. But at some time in the delivery of health care you have to think

about more than the element of the bottom line. You've got to think that these are people out there we're treating.

DR. LAVE: I had another observation. And this isn't called, pick on Alice.

DR. LEWERS: I'm not picking on Alice. I'm picking on the system.

DR. LAVE: As Alice was talking and indicating to Joe why it was that she wasn't concerned about a change in case mix and more expensive patients coming on and less expensive patients leaving was it seemed to me that all of the risk of the patients had been shifted to the providers. That basically that that's what you're really telling us, that -- if I heard you correctly, that you fixed negotiated rates with all of the physicians and all of the hospitals so that if the case mix changes the people who will benefit or will lose from it in fact would be the hospitals and the doctors. Now did I hear you wrong?

MS. ROSENBLATT: Now let me absolutely correct a misperception, in case anyone here is -- I was answering in the abstract as an actuary. I didn't use the words case mix. I didn't talk about case mix. I didn't talk about shifting risk to providers. I want to make sure that no one here is personalizing Judy's comments.

DR. LAVE: But if in fact as an actuary -- I mean, I'm really trying to --

MS. ROSENBLATT: Absolutely, I'm saying if as an actuary I was asked to price a health plan, a health plan out there in the abstract, and that health plan had a 10-year contract $71 per member per month no matter what, then as an actuary I'd load on an administrative charge, I'd load on a profit charge, and that's your price.

DR. LAVE: And what I said is that under that plan all of the risk on changing case mix is placed on the provider.

MS. ROSENBLATT: That's absolutely correct. I'm just making sure that no one was taking your comment to assume that I or my health plan had done that.

[Laughter.]

DR. LAVE: Okay, then I want to come back to the fact that you have not answered Joe's question. Because you answered Joe's -- I mean, I don't know how to -- you answered Joe's question by assuming the problem away from the perspective of the health plan.

So the question is, from the perspective of a real health plan as opposed to the health plan that has 10-year fixed contracts with providers, do real health plans suffer risk when the nature of the provider -- the patients shift? Or in fact have the majority of the health plans negotiated payments, reimbursement systems with their physicians so that either that shift is a shared risk or that the physicians bear the majority of the risk associated with changing case mix?

DR. WILENSKY: I don't think -- I would be surprised if --

MS. ROSENBLATT: Can I just give my glib answer? When you've seen one health plan, you've seen one health plan.

DR. WILENSKY: I don't think we know -- I mean, that is a very --

DR. LAVE: It just seems to me it being one of -- the issue of who bears the risk. I was just trying to --

DR. WILENSKY: The fact is even within a health plan there will be very different arrangements with what goes on in North Carolina versus the physician plan that exists in Florida versus -- I mean, I think that it's very complicated in terms of the relationships. But there are all sorts of relationships, as I understand, within any health plan in terms of some risk, partial risk, full risk being shifted and no risk being shifted.

In some of the open access plans, I think one of the problems that has occurred in the Medicare+Choice is that some of the fast growing plans have been open access plans with very little in the way of monitoring or trying to influence or coordinate or in any way to manage care. It may be less of an issue with some populations, but with a senior population it can be much greater risk.

And particularly if you decide to go pair up with some very well known institutions so that not only are you not used to coordinating that kind of care, but you do something that flags, here is a place where if you're sick and have a lot of complicated care, you can come to us. I think that there was -- if anything, it was really the opposite of this notion of having shifted risk.

My sense has been that there's less of this shifting rather than more of this shifting. But I don't know that I know that, and I haven't seen very much information that lays out all the different relationships with weights attached to them.

DR. LAVE: No, I think that part of the issue is, it would seem to me -- again, I really don't know this -- that the more that the plan bears a risk that probably the more immediate, up-front risk adjusters would be to them as a payment system. Whereas, the more that they can filter it down that the less immediacy the risk adjustments would have. Does that make sense?

DR. NEWHOUSE: You would need it at a level down. You would want it at a level down.

DR. WILENSKY: That's certainly logically correct, as long as you thought that what you did in the risk adjustment didn't make matters worse. But assuming there was any gain, yes, that's certainly what you would assume.

DR. KEMPER: I have a more mundane question. It sounds like there are quite a few administrative issues that are just administrative issues but loom very large in terms of

increasing uncertainty and burden and so on. Is that something that we ought to be commenting on or addressing? If so, is it as part of this payment discussion?

DR. WILENSKY: I would think so.

DR. KEMPER: Just simple things like timing of May versus August?

MR. HARRISON: I think we had originally thought that we would put questions like that into the June chapter sort of with the access in mind. But we could certainly talk about it in the payment chapter as well.

DR. WILENSKY: I think the upshot of what it does in terms of access, and the bottom line is it's really a liability. The seniors will probably have access to the same physicians, but they will have to pay a whole lot more money for a Medigap wraparound than they would have. So it's much more likely to be who ends up paying the extra money than access.

But I would think the issue of administrative features as they exist either by statute or by administrative decision-making ought to be included in the March report because it's as important in terms of the effects on participation as payment is, and it would be disruptive I think in trying to understand payments if we separated them. So if at all possible I would think that would be good. But the impact, the access is clearly a June issue.

DR. CURRERI: I think impact and access is very important. But I think even as important is effect on competition. It doesn't look like too many people are going to be affected by being denied access to some type of managed care program at the present time.

DR. WILENSKY: We're not even sure because all you know, probably that's correct. But what the numbers suggest now, that 10 percent of the seniors live in an area in which there will not be a risk plan. What we don't know is whether the 90 percent who live in areas where there are risk plans have risk plans that are capable of absorbing the additional individuals.

DR. CURRERI: I think the other thing is though too is that it would trouble me if an area had three risk plans two of them dropped out, because now you have nothing for that remaining one to compete with except for other types of traditional fee-for-service essentially.

DR. WILENSKY: And a high likelihood that they're not going to be able to -- if there were very many numbers involved, also a likelihood that they won't be able to absorb the departure of two other risk plans. So it's a little hard to tell how much impact, aside from the 10 percent who live in areas that won't any longer be served is really at this stage hard to tell whether there is a great impact on the others, either for competition or just capacity.

DR. KEMPER: I realize this is heresy, but I get concerned about separating some of the access analysis from the payment analysis because I view a number of the access indicators as really signals about whether prices are set right. So I don't know if we could be a little bit flexible about this divide between March and June on some of those issues. I mean, there are other access things that don't fit very well.

DR. ROSS: I agree with you. It's the face and the obverse of the coin. This distinction that we've been talking about, payment, non-payment, I think more realistically is what do we need to get to the Congress early in the year versus what can we get to them a little bit later. We've got a mandate to do two reports and logistically we can only get so much done by March and only so much done by June, but...

DR. KEMPER: I would encourage you to include indicators of mispricing or update adjustments in the March report because I think it speaks to the issue.

MR. HARRISON: The other problem is that we may not have much data until -- I mean, the new program only goes into effect in January, so by the time we get the data it's unlikely we'll be able to get it out by March.

DR. LAVE: I had sort of an observation and a question. The observation was, where does the quality stuff go and the regulatory aspects of quality improvement initiatives? Is that going to be the June report?

DR. ROSS: That's going to be June.

DR. LAVE: The second issue had to do with, there was a statement in one of your chapters, and I don't remember which one, that you would eventually be getting encounter data. Is that outpatient encounter data or the inpatient data?

MR. HARRISON: The inpatient.

DR. WILENSKY: Are there any more questions?

MS. NEWPORT: Maybe for purposes of the March report we can look at what the Commission would agree would be legislative fix recommendations and then everything else could go to the later report. I don't know if that's too simple of a recommendation or not. Because that would be the time of the year where Congress would start picking up on some legislation.

DR. WILENSKY: To the extent that we can, given data and completed analysis, that's definitely the preference is those areas where we are hopeful that our recommendations or findings might influence legislation we'll try to have included in the March report because the timing will make it more likely that they would have an impact. So we definitely will try to make the split that way. Payment in general will generally be a March. It's what else gets wrapped into that.

Thank you very much, Scott.

Let's move to our last session.

DR. CURRERI: He wasn't finished.

DR. WILENSKY: I apologize. Hardly the issue that I would like to put aside. Scott?

MR. HARRISON: What I wanted to do was take a little step back and get guidance from the Commission on how we want to approach payment adequacy, and there are some questions that we might get the ball rolling with.

One of the basic questions is, what are we paying for when we're buying Medicare+Choice plan? Are we just buying a substitute so that beneficiaries have a choice of the structure of the plan that they're in? Are we trying to give beneficiaries a choice to trade off additional benefits for choice of provider? Are we trying to inject innovation into the Medicare system in general? Or are we trying to generate savings?

I think if we talk about that and see where that goes it might lead us in different directions as to how we want to approach and measure payment adequacy.

And depending on how that first question comes out, how would we want to think about evaluating the payment level? What benchmarks should we look at? Do we want to be looking at the fee-for-service costs? Do we want it to be the fee-for-service costs in a county or in the nation as a whole? Do we want to be looking at sort of a cost-based system where we see how much it costs the managed care plans to provide the care? Or do we even want to look broader and look at how much does medical care cost outside the Medicare system?

Once we've thought about those things, then how do we know when we have an adequate payment level? If plans are leaving, is that a problem? Should there be plans everywhere? It could be that Medicare+Choice plans aren't going to be the most efficient plans for some areas, particularly maybe sparsely populated rural areas? Should everybody in the country have the same benefits at the same price?

The other side of adequacy is it could be adequate for the system on average but is the payment adequate everywhere to give beneficiaries access to these plans?

When we address all those questions then what we might want to do is fit all of the individual payment recommendations into a broader context. Some of the adjustments might mean taking money out or putting money into the system if we didn't make individual adjustments there. So maybe what we really want to do is look at payment as a whole when we think about those individual systems.

DR. WILENSKY: Let me make a suggestion in terms of how we might want to think about this. These are obviously very broad issues that you've raised. It seems to me that with most of the issues -- not all. I'll come back to the one or two very big issues that get left out -- we can follow the legislation as a guide to what the Congress thought it wished to do with regard to setting this up, which was to allow for a way for seniors to receive at least a Medicare package of benefits in a different structure.

And furthermore, with some but not all of these models, to require that savings that the plan could provide in terms of what it costs, what it appears to cost to provide the Medicare package of benefits be given to the seniors as extra benefits.

You can agree or not agree that that's reasonable. But except for the 5 percent less payment which was what the government said, do all that and we want 5 percent savings on top of that, assuming risk adjustment is right, has clearly been, by reference to the legislation, what the government has said.

In terms of the BBA, they have allowed for some areas, some types of plans where it's far less obvious what it would have cost to have done it in a different structure. So the requirement that any savings that could be found get provided to seniors as additional benefits either can't be implemented easily or the Congress has chosen not to press the plans to have that requirement.

So it would seem to me for a lot of these issues that rather than go into major philosophical decisions about whether this is appropriate, that we might at least take for our initial assessment that Congress has said and then reaffirmed in the one case in terms of the risk plans, although allowed much more flexibility for some kinds of plans, particularly the private fee-for-service and some other plans where you don't force that kind of payment.

I think the bigger issue that Congress has not provided clear guidance that goes along with what you've suggested is what role -- how much variation should we allow for in the Medicare program to exist without attempting to intervene? And when we intervene, should we intervene everywhere?

What I'm referring to here is the fact that we have these tremendous variations in per capita spending on Medicare depending on in which state, what part of the country you live in. Up until now Congress has basically implicitly taken the position, what is, is, and if there's a 300 percent variation, so be it. With the legislation, there is an attempt to not allow for that variation in the risk plans.

So we could comment about what that did and what it implied, and whether this was a good idea. But there was not any attempt made to change the variation in terms of the traditional Medicare. So presumably, the same 300 percent spread that became obvious in the risk plans is still going to go on in traditional Medicare where you have very low spending in Nebraska and in Oregon and parts of Minnesota, and very high spending in parts of southern Florida, New York, et cetera.

This issue is something -- because we've really gotten quite mixed signals from the Congress about how much variation is reasonable or appropriate? What would it mean to try to reduce the variation? If we wanted to pick a norm -- Joe and I have been discussing this outside of

this -- is the median a reasonable norm? Should you pick a low spending area like Minnesota or Utah as the norm and not assume that the median has any normative attribute?

It would strike me that in the areas in which we haven't gotten clear guidance it would at least be helpful to point out the mixed signals that Congress has sent by what they've done in the risk plans and what they still allow to occur in fee-for-service.

The reason I'm suggesting that we try to take these different paths is, otherwise it's just a huge philosophical area which I think we would not only get bogged down in, but if we ever got actual agreement I'm not sure that Congress has any particular interest in what this group of 15 actually think about it. But it I think would be very helpful.

But I think the issue of, are the plans doing what Congress through their legislation said they wanted to do? And then, what about this area where there are what I regard as very mixed signals being sent by the Congress about whether a lot of variation is good, tolerable, appropriate? If you didn't like it, how would you want to do it? That, it strikes me, we could at least point out what it means to have done what they've done and what they haven't done.

MR. MacBAIN: If we're going to talk about regional variation, do we really have enough information to know what's causing it? We've got variation in input prices and we have some information on that. There's variation in actual demand for care and morbidity or biological statistics sort of thing. There's reasonable variation in care, different practice patterns, which simply is the way things are done. And then there's genuine undertreatment and overtreatment at the extremes. And there may be more factors.

It's that last factor though that would be a concern from a policy standpoint. I'm not sure the other three are. Can we tease that out? Can we focus on what's significant from a

policy standpoint in contra-distinction to those things that are simply the result of other regional variations?

DR. WILENSKY: I think basically to point out, and to the extent that we can put some relative weights on how much of the 300 percent variation between the extremes we think might be reasonably attributable to cost of living or cost of input differences versus health status versus use patterns I think would be helpful. To the extent that we can't, then we can't.

But it would be within this context that I think that we could at least add something to the deliberations of the Congress. And of course, it didn't seem to stop them in terms of what they were doing explicitly, but by presumption implicitly in saying, a 50/50 blend between the national and the state is just wonderful policy.

DR. NEWHOUSE: ProPAC did do the standardization for input prices, albeit, as Sarah will explain tomorrow, a flawed price index. That shrinks the factor of three more down to 350 to 550; so say 50 to 60 percent.

MR. MacBAIN: If you adjust for demographics and morbidity differences --

DR. WILENSKY: It reduces it by 50 or it reduces it to --

DR. NEWHOUSE: No, it reduces it to. So the standardized numbers in those days went from roughly 350

to 550.

MR. MacBAIN: If you're using the AAPCC as the proxy for regional cost you've also got the other things that are factored in that, particularly the historical factors that have medical education and DSH which further attenuates the spread.

DR. KEMPER: I guess I wonder if it wouldn't be useful to put the discussion of payment adequacy in the context of whatever Stuart gleaned from our discussion of first principles

in the first chapter. In that regard, it seems to me there's a lot of emphasis here on equity and fairness which used in a sense so it didn't loom large in the earlier discussion.

Also adequacy is a term I think probably generated from all the plans withdrawing from the counties. In that regard, I wonder -- I think it's important to distinguish between the level of the payment and the uncertainty created by the changing rules of the game. So I think that's something that confounds the interpretation of the withdrawals from the market.

That the same payment level in a world where there's a stable and predictable set of rules of the game and payment rules could be quite adequate in the sense of drawing forth the supply, but not be adequate in a world where you don't know what's going to happen and you don't know exactly what the implications of risk adjustment are, and so on and so forth.

MS. ROSENBLATT: I just want to add a thought to the geographic variation you were talking about. I don't know if anyone has ever looked at the geographic variation in the under-65 population and compared it to what we're seeing in the over-65 population. There are at least two rate books put out by national actuarial consulting firms, one by Millman & Robertson and one by Tilling, Heston. Each of those books has area factors. I think one of them may even do it for the over-65 population. So it just is a thought for staff.

I don't know about the Dartmouth Atlas but that might be another thing to look at.

Another thought on payment adequacy. I've been giving that a lot of thought and I can't even offer any suggestions. I mean, I may know too much. I may be inside health plans too much. But there's so much going on between the commercial business, the Medicare business. I would really worry about doing this too simplicity, coming to totally erroneous conclusions.

I think you could end up with a situation, as Gail and I were talking about before, where right now you've got a lot of things going on where payments could in fact be adequate but

there's other stuff going on. I only want to offer some cautions about this. I think this is really complex and it's very easy to go down a path that's not going to make sense.

DR. WILENSKY: Thank you.

Tom?

MR. KORNFIELD: I want to introduce myself to those of you who haven't had a chance to meet me. I'm Tom Kornfield. I started at MedPAC in July. I just finished up a master's in public policy from Michigan in May. So I'm glad to be here and I hope that you enjoy this presentation.

The system as it's being proposed here will be operational by early 1999. This means that it won't be in time for the March report but we will have preliminary information available for the June report. In future years, the monitoring system results will be used or will be presented in both the March and June reports.

The system also kind of has short term and long term products. In the short term, which is next year and this is what we're thinking about for the June report, we intend to have baseline data and data on plan withdrawals, including the number of enrollees affected. Whereas in the long term we'll have a monitoring system that has more detail and shows changes in the Medicare+Choice program and may also show what happens to enrollees as they are in counties where plans have pulled out.

I just wanted to summarize my presentation here. The first thing I'm going to do is I'm going to review some of the background, as we've heard here already, about the plan pull-outs from Medicare+Choice. I'll talk about some possible reasons that have been offered by the plans. As I think you've pointed out before, the convergence of a lot of different factors I think has really been a big part of what's happen and it may very well be an anomaly this year.

But I did want to spend the bulk of the presentation on the monitoring system. The system has four main objectives as proposed by us. It will track beneficiary access to plans. It will analyze characteristics of affected counties, which are counties in which there's been either growth in plans or declines in plans. We'll also monitor enrollment. So this will be changes in enrollment. And we'll also look at plan characteristics and benefit packages.

There's a 1998 baseline for the system which reflects where data is now. This system will have annual updates, except in the case of enrollment which will be quarterly. So the main goal of the presentation here is to present the system to you and to get feedback on how the system should be structured.

As we've heard or has been reported a lot in the press, the plan withdrawals and service area reductions, it was estimated that they'll affect 450,000 enrollees, and 47,000 of these enrollees will no longer have access to actual health plans.

Now I did want to point out that 450,000 figure, that's 2 percent of the total beneficiaries in the affected counties. But again, this is preliminary data. We haven't had a chance to really look at it in depth and do the kind of data quality checks I think that we would like to do. And it's also been provided by HCFA and we haven't really been able to see the data sets that underlie that.

DR. CURRERI: What's the net here? Have any of these areas gotten new plans that have come in? What's the net change?

MR. KORNFIELD: That's something we don't know yet. That's why I'm saying it's preliminary. There's 48 new risk applications. There's a number of plans that have also applied to expand their service areas but at this point we don't know in which areas. HCFA has just reported on the given areas. I don't know if Janet...

MS. NEWPORT: The number I think is right. I think you're on track here with something. The important piece is how old are those applications? Because what you need to understand is that HCFA was encouraging back about a year ago this time, get your applications in early because once July 1 comes around this year they were going to give priority to PSOs. So filings may have been done, or may be soft because there may be folks that will say, now under what they perceive is a new environment they would not want to continue with that.

So I can't judge how soft that is, but I think we need to watch that space very carefully.

DR. LAVE: Could I ask about plan withdrawal? That is that if I am a plan and I withdrew this year from area A, to what extent should one assume that that would be a permanent withdrawal? That is that's unlikely that the plan would go in again next year. Because if I were a beneficiary, it seems to me it would make me sort of angry if plans come and go. So I wanted some sense about the permanence.

MR. KORNFIELD: That's one of the things I was going to address down in the next part. In the sense that

-- I'll go down these and eventually I'll get to your question. There have been several reasons that have been cited by plans for the plan withdrawals.

One has been that the payment rates were lower than expected. Plans have expressed concern in that they expected to get the blend and then because of budget neutrality they didn't get the blended rate, so their rates weren't as high as they would have liked and they got the minimum -- I'm sorry, they weren't as high as they expected. In other words, they got the 2 percent minimum increase.

There's also a lot of uncertainty about risk adjustment and this kind of gets back to some points that were expressed earlier about the certainty in the program and been replaced now by a lot of uncertainty about what's going to happen when risk adjusters are proposed.

There's also an earlier ACR deadline which was mandated in the Balanced Budget Act. HCFA did choose to use that deadline this year, but in future years that is the legislated deadline. That's not a HCFA-imposed deadline in future years. I just want to make sure everybody understands that.

Then of course, there's been a lot in the press about increasing drugs costs, and a lot of studies have looked at that. This has been a trend that's been going on now for a couple of years in the health industry.

Then there are concerns about regulatory requirements, particularly the quality requirements, data reporting requirements that are in the Medicare+Choice regulations that came out at the end of the summer, middle of the summer.

Finally, one last reason -- one last potential reason I should say, is that the five-year lockout does not apply. This is getting to your question, Judy. In previous years, if the plan had pulled out they would be locked out of the risk plan program for five years. But because this is a transition year, a plan can pull out this year -- that is, not become a Medicare+Choice plan. But then they can wait a year and then come back in.

So in other words, they're not locked out for five years the way they would have been under the risk plan program. So it's just kind of --

DR. LAVE: But surely they would think that the beneficiaries would be a little cheesed off.

MR. KORNFIELD: I can't speak for what the plans would think.

DR. NEWHOUSE: But they may appeal to a different group of beneficiaries when they come back.

DR. LAVE: That's true.

MS. NEWPORT: It's not something you can just do. You've terminated your provider contracts, your hospital contracts, whatever. You're not going to be back in a year realistically. So I think that there was some early concern that the five-year would apply, but that has always been traditionally at the discretion of the Secretary. If there was some compelling reason to allow someone to reapply that could have been waived before.

DR. LAVE: Could I ask, I had a couple of questions about the pull-out. I don't know whether or not--

DR. WILENSKY: If it's a clarification that you don't understand a point being made, but otherwise why don't we go through the presentation and then have questions.

MR. KORNFIELD: I was just going to say since a lot of the data at this point is really preliminary, it's too early to suggest appropriate solutions without getting really good information. So in the remainder of the presentation I'm going to lay out our preliminary look at the monitoring system to evaluate program trends in the Medicare+Choice program.

The monitoring system has two main goals. They are to measure a series of data elements and then to analyze a series of relationships. We intend to measure the extent of plan pull-outs, impact on access for beneficiaries, and then changes in enrollment. So the extent of plan pull-outs we'd want to know what's going on in the program, how extensive are the plan pull-outs? This gets to your question, Bill, about plans coming in and plans going out.

DR. CURRERI: I was just going to say, I think you have to not only measure plan pull-outs but those coming in.

MR. KORNFIELD: Plan additions, right.

DR. CURRERI: Because plan pull-outs may occur because of bad business decisions and the market may still be very attractive, attracting other people in.

MR. KORNFIELD: Right, we do want to look at net changes.

I guess impact on access, we want to look at our enrollees losing access in some of these areas. This means, did they used to have access to risk plans and they no longer have access, or a Medicare+Choice plan. There's certainly a lot of areas that are not currently served by risk plans.

But we want to look both at that and then also whether or not there are areas that were served by risk plans in previous years that are no longer served, or I should say in 1998 that in 1998 are not served by risk plans, and enrollment changes. So how these changes affected enrollment in Medicare+Choice. Has total enrollment gone down, gone up? If there have been changes, where have the enrollment increases been, or where have the enrollment decreases been?

DR. LAVE: Excuse me, can I come back to an earlier question. This 450,000 enrollees, these are 450,000 enrollees in HMO plans --

MR. KORNFIELD: Risk plan enrollees, right.

DR. LAVE: That withdrew.

MR. KORNFIELD: That have announced their intention to withdraw. That's why I'm saying a lot of it's preliminary because, for example, Anthem I think had initially announced they were pulling out of I think 23 rural counties in Ohio and now I think it's 13 I had read. So there are potential changes along the way. That's why I think it's important we look at the whole system.

We also intend with the system to analyze relationships between plan pull-outs and payment rates. That is, are the pull-outs occurring in maybe the floor payment areas? Is there any kind of relationship between payments and the plan pull-outs, and plan pull-outs and benefit packages? That is to say, is there any relationship between plan pull-outs and maybe generous drug coverage, or premiums being charged, or copays, or any of those types of characteristics that we want to look at.

I should also point out that an important component of this in the future is going to be looking at the plans that are coming into Medicare+Choice and the plans that are staying in Medicare+Choice. What kinds of benefit packages they're offering. Whether or not they're coming into high payment rate areas, low payment rate areas, if any of that really is affecting changes in the program.

I should also point out that the system is designed as an early warning system. So it's hopefully going to track problems as they -- if there's a problem that arises, hopefully we'll be able to spot it in its early stages and then address it accordingly.

The monitoring system has four basic components which closely track the goals that I was talking about earlier. They are to track beneficiary access to plans, analyze characteristics of the affected counties, monitor enrollment, and monitor plan characteristics and benefit packages. We intend to track access through a series of county maps that will show net plan growth and plan decreases, and the presence or absence of plans with drug coverage.

This is a sample map which is actually from our July report. I want to emphasize this is a preliminary map. It doesn't represent actual announced plan pull-outs or anything of the sort. It's from an earlier data set. But it's designed to show you the kind of map that we intend to generate which would show you areas that have lost risk access.

You could also do this to show counties that have certain types of drug coverage or certain types of benefits, that sort of thing. There's a lot that you can do with this kind of a map. And I think it also gives you a sense as to where the change is actually happening. Are these widespread? Are these specific areas? Just kind of put everything into perspective.

We intend to analyze the characteristics of the affected counties. This will include reports on the counties affected and how they differ from counties not affected, let's say. These could be, again, counties that the comparison could be with counties without changes, counties with growth, counties with decreases. There's a lot you can do with the changes in terms of what you want to estimate.

The data elements that I've included here are selected ones from the mailing material. I think it's

Table 2 in the material that was sent to you. So that gives more detail, but these are some of the main ones that I wanted to focus on or to at least mention. We intend to look at net changes in number of plans and counties, the net change in enrollees, the payment rate. Both the combined payment rate, Part A and Part B.

The payment category, whether or not this was a blend, a floor, a minimum. That is, was this a county that got the blended rate, the minimum update or whether or not it's subject to the floor. It's not exactly a parallel structure. Then we'd also want to look at the payment rate and how it compares to national and regional averages. Again, this is sort of getting at this notion of high payment, low payment areas.

As I mentioned before we would be looking at enrollment. I haven't listed it as a separate data element because it's just basically looking at how enrollment changes within a given county.

We also intend to look at plan characteristics as well as the benefit packages that they offer. This could include -- I should say about the enrollment, we do hope in the future to look at whether or not enrollees that are in areas where an HMO has dropped coverage actually go into another HMO or if they go into fee-for-service. That's something that we would like to do over time. But again, that's more of, I think a long term focus of the monitoring system.

So with respect to plan characteristics, we intend to look at number of enrollees in a given plan; the model type, whether or not it's an IPA or a group or a network or staff or mixed. Then look at the annual premium, whether or not they charge an annual premium. As we know, a lot of plans currently don't charge a premium.

The financial characteristics. This could include items like medical loss ratio or administrative loss ratio. Some of these are used in the industry to show whether or not they have relatively high overhead rates, let's say.

Then also look at market penetration rates. So this could be both do they have a high penetration in the counties that they're in, and does managed care have a high penetration in the counties that they're in. This will give us a sense as to the market in that area.

DR. CURRERI: I was just thinking that it might also be important in looking at plan characteristics, if it's possible to get this data, to look at the risk adjustment factor. That might be a clue of areas where risk adjustment needs to be improved. If certain plans with either high or low risk are dropping out, it might indicate to us that we need to do more work with the risk adjustment factor.

MR. KORNFIELD: With the risk adjustments that are being proposed you mean?

DR. CURRERI: Right.

MR. KORNFIELD: Yes, again that's more of a long term type goal. But I imagine that could be something and should be something that will be included in the monitoring system.

The last component that I have there is the benefit packages being offered by plans. We'd want to look at -- as we know, drug coverage has been one of the main reasons cited by beneficiaries in terms of why they have chosen to enroll in an HMO, because Medigap policies that cover drugs are fairly expensive.

I should also point out that HCFA is requiring certain types of Medigap plans to offer coverage to enrollees that are in areas where they lose coverage in an HMO. But none of those Medigap plans includes drug coverage. So I think that's something to keep in mind as we're looking at this.

In terms of drug coverage, we'd want to look at what the copays are, whether or not they have an annual limit. Also if we have this kind of data, and I'm not certain that we do, but issues like formularies and that sort of thing, that may be something we want to look at in the future. But I don't think that's in the current data system. So that's something that we would have to analyze a lot more and think about more.

And then routine physicals is just another example of the kind of benefit package that we could look at. The main thought in including benefit packages here is what they offer relative to regular Medicare and why people are signing up for them, and I think drug coverage is really the most important one there.

That concludes my presentation. I'd be very happy to answer any questions you had about the system, or any kind of suggestions you might have would be much appreciated.

DR. NEWHOUSE: It wasn't clear, but were you going to keep enrollment and disenrollment separate? You kept referring to net enrollment, but I think it would be interesting to know --

MR. KORNFIELD: Yes, I think we did intend to keep it separate and then the net enrollment would be what --

DR. NEWHOUSE: Right. But it would be interesting to know the gross flows.

The other issue was you didn't really say anything, or if you did I missed it, on MSAs and private fee-for-service.

MR. KORNFIELD: There haven't been any MSAs applications so I haven't discussed that. As those plans come in, there's four PSO application. There's one PPO application. So that's something that I think we will certainly monitor. But it's just currently there aren't any applications for those plans, so that's why I didn't explicitly discuss them.

DR. NEWHOUSE: But you would also -- I think it would be worth thinking about what characteristics of those plans you would want to monitor.

MR. KORNFIELD: We would, yes. Once they actually apply we'll definitely include them.

MS. ROSENBLATT: As you know, I've been a strong supporter of doing this kind of monitoring so I'm real pleased to see that we're going to do it. Could you put the last overhead up for a minute? I've got a lot of very specific recommendations on what you should be monitoring and how you should be monitoring. First I'm going to put my actuarial hat on again and quote something that was in an actuarial study note that I read 20 years ago, but it said you could drown in a lake that averages three feet deep.

I'm real worried in your plan characteristics that if a given plan has two different plan, maybe one with drugs and one without drugs, you need to deal with them separately.

MR. KORNFIELD: Right.

MS. ROSENBLATT: Because the pricing will be -- everything will be different about it. It wasn't clear to me from -- you're nodding your head so it seems like you've already worried about that.

MR. KORNFIELD: Right. That's a good point.

MS. ROSENBLATT: The other thing that concerns me is when you talk about, the wording that was in the material we got said financial characteristics of parent company.

MR. KORNFIELD: I'm sorry, that shouldn't have been in there. I was wrong on that.

MS. ROSENBLATT: But it does raise the question of what company are you talking about? You mentioned Anthem. Are you talking about the Ohio plans?

MR. KORNFIELD: Again, being new to this area, there's still a lot I am learning. One is the way that the health systems are structured. The orange blanks, I was under the impression that that had some relationship to -- the orange blanks being the financial, the filings with states. But I know it doesn't have. I know they're separate. So I realized that the parent company that was in there -- that was an oversight on my part and it shouldn't have been there.

MS. ROSENBLATT: You're going to run into a lot of problems trying to do what you're trying to do. Let me just give you a little -- the kind of problems you're going to run into. One is you're going to find that plans that are multi-state probably file different orange blanks like you're talking about in each state.

You're also going to find that the loss ratio on that orange statement is for all products. So it includes a lot of commercial business. You're not going to be able to find a Medicare risk loss ratio through things like statement blanks. So basically what I'm saying is, once again, in order to draw conclusions about the Medicare risk program you're going to need to be real careful about your data.

Another data that might be interesting, if you are going to look at -- I might add a criteria, let me put it this way of -- and I don't know if you can find it. But what is the Medicare risk population versus the total population of the health plan? What percent -- if the total health plan has 100,000 members and 90,000 of them are Medicare risk, it would be a 90 percent number.

MR. KORNFIELD: I think that's something that we could do with some other data sources like Interstudy.

MS. ROSENBLATT: That might be interesting. You might also look at size of the health plan. Is this a $1 billion health plan, a $1 million health plan? Because that size might drive a lot of the decisions that you're seeing.

Just one thought on enrollment. In the material you handed out you were talking about monitoring enrollment from the same quarter a year ago. I think you need to actually measure change over quarter to quarter. I would look at it quarter to quarter. I would look at it this quarter versus the same quarter a year ago. And I would also always look at calendar year to date because January 1st is just a real big date and funny things are going to happen. So I would try to look at trends over all three types of time periods.

MR. KORNFIELD: Right. I guess the reason I was thinking of that is just in terms -- everything else in the system is based on an annual basis. So I was thinking second quarter to second quarter in the sense of an annual change. But we can certainly look at other changes.

MS. ROSENBLATT: If you really want this to be a monitoring system that's going to give you early warning, you definitely want to look at the quarter to quarter change.

MR. KORNFIELD: Right. I do want to point out though that the open enrollment, there's going to be open enrollment periods that are going to be in place I think in 2003 or 2004 -- I'm not exactly sure of the --

DR. WILENSKY: Annual enrollment.

MR. KORNFIELD: Right. So the quarterly enrollment, these changes won't be -- in the future you'll only be able to enroll at one point during the year so it's only going to be annual in nature. So it's not a factor now, but in the future it will be.

MS. NEWPORT: On the reasons cited by plans you might want to include providers terminating contracts with plans. I think it varies all over the place, but it's what I call -- we were exited as opposed to we were exiting. I think that there is -- I don't know how big a deal this is but it may be something worth asking about to determine whether it's worth discussing.

I guess what I was concerned about, and I don't know what to recommend is, the you can drown in a lake that's three feet deep is, is there -- I was trying to see if there's a recommendation I could come up with in terms of looking at what would be two or three data elements that might be key indicators. I'd put in one and take off another and then I'd want to -- so I guess I would try to I think start with the plan pull-outs and see if you can understand that and look at the net changes in enrollment.

I think that what you might find -- and you may want to look at benefit packages geographically. There may not be a national trend in that. There may. I don't know. But that may be something that we might be different in California than it would be in New York.

MR. KORNFIELD: A lot of those, with regard to benefit packages, that's something that we were thinking in terms of the maps that we were going to develop, that we could put some of that in there as well as in summary reports.

MS. NEWPORT: Just leafing through here, I think that's it. I think that it's worthwhile being able to understand what the characteristics of market shifts are. So I'm not sure that model type is -- that may be one that you want to take off, but I guess you just have to measure that. I would suggest you start as simply as possible and then build up.

MR. KORNFIELD: Right. We have that in mind, I think, in terms of short term products versus long term products. In the short term, we do want to look at the plan pull-outs and what's happened there. And then we want to also put -- lay the groundwork for a system that can do a lot more than just look at changes within a given year, but also look at how the program is changing over time. This is something that in the future I think will be of pretty good value to the Commission.

MS. NEWPORT: One other comment on the supplemental coverage post-disenrollment or exit by the plans. There is an issue there in terms of the states were, under BBA -- I don't know if it was a suggestion or a mandate -- were supposed to enact legislation that would eliminate the preexisting condition requirements on the Medsupp.

This, I think is a place to watch, particularly in January and February because the beneficiaries have only 61 or 62 days to elect that coverage, and none of the states have had time to enact the legislation to do that. I think that NAIC has got some model legislation but none of the states, most of the states haven't had their legislative sessions to do anything about it. So this could be a bit of a fuss. It will be more than that.

DR. KEMPER: One thing you might think about for the longer run is measures of competitiveness in the market.

MR. KORNFIELD: That's a very good point. Those are things that I think we really would like to look at, like what's going on actually in the private sector.

DR. KEMPER: I just really meant the extent of competition in the Medicare market.

MR. KORNFIELD: Within an area or were there specific data elements you were thinking about?

DR. KEMPER: As it would be constructed from number of firms and Medicare market shares.

MR. MacBAIN: I think it's also interesting, if you can find that a market is intensely competitive for commercial business and there is no Medicare risk competition, it tells you there's something odd going on.

DR. WILENSKY: Any additional comments?

DR. LEWERS: Just so that I'm clear, the maps you showed here, the one that's in the paper, they're not in any way representing these counties?

MR. KORNFIELD: No, they don't. They're from the July report. I just pulled charts that had been generated for that. But they have absolutely nothing to do with the plan pull-outs. It's just for demonstration purposes. I want to keep emphasizing that.

DR. LEWERS: Because they don't match.

MR. KORNFIELD: They don't match because they're different charts because Sarah suggested I use a different one.

MS. NEWPORT: One other issue, I don't think that the exits are over. HCFA has not even sent out to the plans the contract for 1999. There may be more. So I don't think the number that you have should be viewed as final.

MR. KORNFIELD: Yes, and that's why -- I think that's a very good point. They have until November 2nd, I think, to notify beneficiaries; is that right?

MS. NEWPORT: I guess so. No one has seen the contract yet.

MR. KORNFIELD: That's what I understand is that they have until November 2nd. So there could very well be a lot more pull-outs that we haven't heard of.

DR. WILENSKY: This is clearly, as is I think obvious, the beginning of what will be ongoing monitoring. So we will, as we see what comes in, I'm sure have other thoughts about what we need to add or modify.

Thank you. I think it was a very interesting presentation, a very good first presentation.

MR. KORNFIELD: Thank you.

DR. WILENSKY: We have a few minutes for public comment, if there's anyone who wanted to raise an issue over the last two sessions.

[No response.]

DR. WILENSKY: We will end here our public session for today. We begin at 9:00 in the morning and will go through 12:15 with two major sections tomorrow. Thank you very much for participating.

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.
Friday, October 30, 1998

The meeting in the above-entitled matter convened, pursuant to notice at 9:08 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair

P. WILLIAM CURRERI, M.D.

ANNE JACKSON

SPENCER JOHNSON

PETER KEMPER, Ph.D.

JUDITH LAVE, Ph.D.

DONALD THEODORE LEWERS, M.D.

HUGH W. LONG, Ph.D.

WILLIAM A. MacBAIN

JANET G. NEWPORT

ALICE ROSENBLATT

JOHN W. ROWE, M.D.

C O N T E N T

P R O C E E D I N G S

DR. WILENSKY: Good morning, everyone. We're ready to begin the morning session for today. We have two major areas of discussion and we're ready to begin on the first which is adjusting Medicare+Choice payments for price level differences among areas. Sarah?

MS. THOMAS: Good morning. The materials for this presentation are at Tab F in your binders.

The Medicare+Choice payment formula requires that the national rate be adjusted for geographic price differences before it's blended with the local rate. The blended rate is only one of three possible rates a county might get. Other possibilities are the payment floor and the minimum update. Neither of these amounts are adjusted for price differences. This is one of the topics for the March report which Scott outlined yesterday.

The main purpose of the adjustment is to neither penalize nor reward plans because of the price levels in the geographic areas they serve. This is a principle articulated by Joe and Gail in the letter they sent to Congress during the drafting of the BBA.

Today I'm going to focus on the concern section in the paper and I'm hoping that your discussion will be to some preliminary recommendations. One way to go about this is to think of the ideal adjustment system and then take on more practical issues to translate the ideal into something feasible.

There are basically two pieces of the adjuster. One is the cost weights, which tell you how costs for a particular service or product break out. The second is the index or indices which measure geographic variation in the price for each cost component. I'm going to briefly go over the interim formula that's in the statute now. This is in the statute as an interim formula and the actuary is not in any way wed to this formula.

Basically, one takes the national Medicare+Choice rate, separates it into Part A and Part B shares. You take the Part A part and adjust 70 percent of it using the hospital wage index. Then you adjust 66 percent of the Part B amount using the physician indices, and adjust 40 percent of the remaining 34 percent of the Part B spending using the hospital wage index. The cost weights are based on fee-for-service spending experience, and the indices measure variation in price levels for hospital and physician inputs.

Now I'm going to briefly review the concerns in your mailing materials. I'm going to start with the three bigger picture issues and then follow with the rest. This first set of issues are that the index is based on the inputs to services, that it only includes hospital and physicians, and that the cost weights are taken from fee-for-service. The chart on the next slide illustrates this set of issues.

The entity that gets the Medicare+Choice payment is the health plan. That plan incurs administrative costs and pays providers for their services. Providers in turn pay for their inputs, wages, rents, supplies, and what have you. Under the interim index there's an implicit assumption that you can or should use variation in provider input price levels to measure variation in the prices health plans pay for services. This may not be the case though.

First, providers may use their inputs in different combinations than we see at the national level. For example, when some inputs are relatively more expensive than others.

Second, provider supply and plan purchasing power can lead to price levels that don't necessarily fully reflect the price of the underlying inputs. As is pointed out in the paper though, you might not want to use provider prices directly if you think they're overly influenced by plan market power.

The second issue is that the interim adjustment only explicitly recognizes physician and hospital services. As you can see from the middle boxes, health plans incur administrative costs like running quality assurance programs, paying claims, marketing, customer services and the like, and also pay for other health care services. The current adjustment doesn't adjust for variation in any of those costs.

The final issue is, as I mentioned earlier, that the cost weights for the services are taken from fee-for-service spending experience, which is most likely different from the shares experienced by Medicare+Choice plans. Plans claim, and their ACRs bear out, that they use relatively more physician than facility care.

I'm going to quickly mention some of the other issues in the paper. First there's the difference in the geographic areas used in the hospital wage index and the geographic practice cost indices, or GPCIs. The former use MSAs and statewide rural areas and the latter use states and aggregations of carrier areas. The data for both indices can significantly lag the payment period. And the GPCI for physician work, by political design, understates variation in input prices. And finally, the actuaries have recalculated the indices to reflect beneficiaries tendencies to travel for care, but the approach could lead to some volatility in values.

On this slide is your recommendation on the adjustment from last year's March report. It was somewhat unclear whether you meant HCFA to move in the direction of measuring service prices or whether you wanted to change the cost weights or whether you wanted to include the other health plan cost components. You may want to start your discussion of this year's recommendation with these issues.

Some practical issues are raised by the words, as soon as feasible. I did want to mention that it would be expensive and difficult for HCFA to initiate a new data collection effort.

You might to think about whether you could take cost data from the ACR, combine it with service use information plans are submitting as part of the risk adjustment system, and get a reasonable measure of service prices. That is if you want to go the service price route.

This last slide may give you some ideas on recommendations. First you may want to think about whether to use service prices or input prices and whether we need indices for administrative costs and for non-hospital physician services. This will probably drive whether you think that you can use existing data sources or whether you need something else, with the likely alternatives being a new survey or modifying the ACR.

Next you might want to think about improvements to the system that would not involve new data collection, like changing the cost shares, allowing all the variation in physician work GPCI, and making consistent payment areas. You might also want to consider having HCFA or someone else study the question of the relationship between service and input prices and raises some of the design issues for that study.

Depending on what you think of the big picture questions you might want to get into some of the details of what a new system might look like. If you get that far, the last slide in your package may help organize your thoughts. But you probably will want to focus on the big picture of what you think needs to be fixed first.

That's all I planned to say, but I'm happy to answer any questions.

DR. ROWE: Sarah, one question. You said one of the problems was that these other providers were really not included.

MS. THOMAS: That's right.

DR. ROWE: What proportion of the total expenditures do they represent?

MS. THOMAS: We don't have a tremendous amount --

DR. ROWE: Is it a big problem or a little problem?

MS. THOMAS: Administrative costs could be as much as 15, 20 percent of the pot. We have some information from the ACR on some of the other components, but it's a little bit sketchy. It looks like skilled nursing facility is about 4 percent, and I'm not sure about home health.

DR. WILENSKY: Can you do the flip side of it? How much are we accounting for by hospital and --

DR. ROWE: That's really the question.

MS. THOMAS: Again, this is on Table 3 in your mailing materials. On the ACR it says administrative is about 16 percent, and then inpatient hospital is about 44 percent -- I'm sorry, with hospital being 40 percent of inpatient, skilled nursing being 4 percent, and then physician being 32 percent. So those are the major parts of it. I think though the biggest part that's left out is admin.

DR. ROWE: Thank you.

DR. WILENSKY: Basically three-quarters of the costs are covered by this.

MS. THOMAS: Right.

DR. ROWE: But there's a lot that's not.

DR. WILENSKY: Yes.

DR. NEWHOUSE: I'll put out my answers to some of your questions. These are kind of conceptual before I've really had a chance to hear about administrative problems, so since I suspect some of the differences aren't all that great, administrative things could, or data collection could tip it one way or the other.

But I think conceptually you'd want to use service prices rather than input prices, because you're pricing, in a sense, what the plan is being for rather than the supplier to the plan is

paying. I would think you would use cost weights that were for Medicare because that's the product we're trying to price. And I would think you would use the basic benefit package rather than all Medicare+Choice benefits. First of all, the latter varies by plans, so it would be difficult to...

Then I would think the plan universe here would either be HMOs or Medicare+Choice plans. For the moment, that distinction doesn't seem to be terribly important. So that's where I at least came out in my first pass through this.

DR. WILENSKY: You may want to have other commissioners think about whether there is any other discussion on these issues, or to the extent that you feel comfortable in terms of these distinctions we can use that as a first approximation.

MS. NEWPORT: First, I bow to more experience on the Commission in terms of price indexes, but I just have, I think, some basic questions. Does this at all get to the issue of assuring that there would be blend counties?

MS. THOMAS: No.

MS. NEWPORT: So there's no linkage there?

MS. THOMAS: Whether there are going to be blend counties depends on the amount of the update.

MS. NEWPORT: I just want to make sure I did understand.

MS. THOMAS: Yes, this is really sort of a distribution, or how much of the blend you get, kind of.

MS. NEWPORT: I guess the one concern -- and I think I understand this at a basic level -- but what's the recommendation on a state versus a smaller local level? What seems to work traditionally in terms of these indices?

MS. THOMAS: Both of the predecessor commissions has problems with the payment areas for each of the relevant indices, so there's no one answer. ProPAC didn't like MSAs and statewide rural areas because they thought they were too big, and PPRC didn't like the carrier areas and statewide areas because there were strange boundary effects basically.

DR. NEWHOUSE: Well, they were arbitrary.

MS. THOMAS: And they were arbitrary, right.

DR. NEWHOUSE: I mean, it varied by state. There was no consistent policy.

MS. NEWPORT: Have you measured the changes in the ACR proposal to see if they get at least as a first step towards an index? Have you measured that compared to what--

MS. THOMAS: The new ACR methodology is supposed to require plans to provide information on their past costs, and they use that as a base for projecting their rate. So one idea that you might think about is taking those cost amounts and then you simply need to pull in the encounter data, or not. I mean, this is actually something I was thinking about as I was walking in today. You might be able to do something like this on a per-member-per-month basis, but then you don't get the volume taken out.

But presumably, if plans are reporting their service use data and they're also providing their cost data, then it could be a simple calculation of what their cost per service is.

MS. NEWPORT: Maybe as a suggestion out of that response we may want to look at, not a demo, but an effort over the next year to take a look at some of the new filings to see if there is something that's usable out of that. I don't know the answer obviously, but we might want to look at it that way. I think that's it for now.

MR. MacBAIN: A few questions. One Ted may have some insight on, and that is the effect of using the physician wage index on rural counties. I just know from working with an

organization that recruited a lot of physicians into rural counties that while we weren't necessarily competing at the same market price level with New York City, we were competing in a national marketplace. And in fact had some unique characteristics of rural communities that unlike recruiting into a city where people can live in a lot of different settings, if you're recruiting to Danville, Pennsylvania people are either going to live in Danville or they're going to live in another community very much like Danville. So that can end up driving up the cost of recruiting and retaining physicians above what otherwise would be a professional wage index in the area.

Ted, do you have any sense of, is it a good, valid measure for rural counties?

DR. LEWERS: I think so. I think that's part of it. I think that there's no question that you just can't take one figure and add it to everybody. That's very simple. I think there are other areas -- while I've got the microphone -- that bear with that, and that is the shift that can occur to the sicker patient going into the plans or not into the plans and how is that taken in. I don't see that taken in as far as -- I'm talking about physician involvement at this point in time. So I agree with you.

MR. MacBAIN: Which could change the mix. The other thing that again is an issue for a rural plan is the extent of services provided outside the rural area, which is likely to be higher, and if you don't capture that in the way the index is used you end up underpaying.

MS. THOMAS: The way that the actuaries have -- if you can use fee-for-service patterns as a proxy for what you would -- and that's a big if -- the way that they've recalculated the index is to actually take into account people traveling across, from rural areas to MSAs. So they've actually sort of reweighted them, not to reflect the price levels of the providers in the area but to reflect the price levels of the providers used by people who live in the area. So it's sort of like a composite of if you go out and stay in, they would weight that amount.

MR. MacBAIN: Another thing I'm a bit concerned about and that's the use of HMO data only or either ACR data as a way of either trying to determine price levels. Maybe it's a little bit better for trying to come up with the right weights, but that doesn't do much for a PPO or an MSA, nor does it do much for a plan trying to start up in an area that doesn't have a whole lot of prior ACR experience. Even in areas where there are a number of HMOs, at best you're reflecting the way those HMOs functioned a couple of years ago. The enrollment in HMOs is still small enough that the intervening two years could result in significant changes in the mix of services, where they're being provided, what the HMO's contracts look like. So I've got some concerns.

I think maybe in determining the weights, the relative weight of a physician wage index versus a hospital wage index versus administrative costs you may get a little more guidance. But even that I think needs to be tempered by the fact that there are going to be other kinds of plans coming down the pike.

The other thing I wondered is whether it would be possible to do a study, an in-depth study of what the real costs are in a few representative areas around the country, and then see if there's a way of mapping existing indices against that. That's kind of what the interim approach does except it doesn't have anything to map against. It's just sort of -- a percentage is taken out of the air.

But it might be possible to figure out what the right indices are and what the right weights are in order to come up with a proxy for the real numbers, if we do a study to come up with the real numbers in a few areas. That then could be repeated, say every five years, in order to revalidate the approach. But in the meantime, for the intervening four years, you've got a proxy and you don't have to do this full study.

DR. KEMPER: Two comments. I guess the first is, it's not clear to me whether service prices are what we want or whether we really ultimately want input prices. In a sense, if you think of it as an integrated delivery system, or if you think of lots of capitation getting pushed down to providers, then it's really the provider inputs where all the decisions are being made and where the benefits of efficiency would accrue. So it's not clear to me whether it ought to be input prices or service prices.

I guess the second question I have is, to what extent -- and this is cheating a bit because it's going from the principle to the constraint which Joe didn't want to do right away. But how much can, given the cost of collecting these, to what extent could improvements in the indices needed for fee-for-service also be used here? That is to try to integrate the whole set of price indices that are needed and improve those with one objective being improving what could be done on the plan payment side. That would drive you necessarily I think to the input prices.

DR. NEWHOUSE: A couple of comments. On this last point, I was just starting from the precedent really of the Consumer Price Index and the Producer Price Index, and they both take, as it were, final prices. The Consumer Price Index, for example, asks what is the price of the refrigerator. It doesn't ask what is the price to General Electric of the steel that went into the refrigerator. And similarly, the Producer Price Index asks what price GE is charging for their refrigerator, not what wages it paid.

So it seemed to me the general notion of a price index was to not go two levels down. But there's where I was coming from.

Now the caution I would have for us in thinking about this is that we can't be too local with this thing. The whole theory of price index is that you're measuring some kind of

competitive price, or at least a price that the person, the producer, the firm can't affect by its own actions.

So if, to take the extremes, you got to a rural area with one hospital and the health plan goes into that area and writes a contract with the hospital, and then you say, what's the price the plan is getting from the hospital and we're going to adjust for that. Then the hospital can keep raising its price and that just gets passed on through in this price index. So the index has to be across a broader geographic area than that, and enough to have, I would think, several firms so that no firm can importantly affect the index by its action.

The second thing is that I don't -- you kind of allude to this, Sarah -- that you can't use the CPI and the PPI because they kind of have thin national samples and we're after what I'll call a cross-section index; that is, an index that goes across space -- and that's right. But what it made me wonder is whether we should do this cross-section index, if we're going to do it pretty infrequently, and use a thin kind of national number to update it in between.

What I didn't know what whether once you had set up this machine that was going to chunk out the cross-section index, whether it chunked it out for fairly low cost each year or whether there was a lot of cost each year to producing the index. I sort of suspected it was the latter but I wasn't sure about that, in which case going then to a thin kind of national sample would seem to me to be attractive.

On Bill's point about the small HMOs, they presumably would get not much weight anyway. So I'm not sure it would be worth the -- the theory of the price index is, to the degree we're doing it, I think, is that we're facing -- there's some kind of competitive price out there that plans have to pay for this service or that service, and that what -- it's changes in that competitive price that

we're trying to measure. Now the problem is it's not always a competitive price, and the price index doesn't adapt very well in that situation.

But I still think that the going-in assumption anyway is that there's some kind of market price that any firm that comes into the market is going to have to pay.

MR. MacBAIN: I think I'm drifting toward Peter's view on this of looking at the input costs because of that, because there is not a good analog for the refrigerator. If you look at the prices, you end up looking at prices for a zillion different independent components that end up being mixed in a variety of different weights and quantities across a spectrum of patients. Whereas, you can boil that down to underlying all of that of the cost of operating facilities, paying salaries, keeping doctors in practice. So it may make more sense to try to get to a more general variable at the level below all of this price activity in all the discrete services.

DR. NEWHOUSE: I guess the issue is, suppose you had a local -- let's just take a local monopoly hospital. And suppose that the hospital is in a reasonably competitive market for wages, so you can go down to the wage level and you can find a competitive wage. Then there's some kind of markup in the hospital that the plan has to pay. And suppose now that markup changes for some reason. I think the conceptual question you want to ask yourself is, should this index be tracking the change in the markup or not?

MR. MacBAIN: No.

DR. NEWHOUSE: I would have said yes, because it's a price the plan is going to have to pay to contract with the hospital. But I think that's the nub of this issue.

MR. MacBAIN: The difficulty is it's a monopoly hospital.

MS. ROSENBLATT: I just want to say I do think geographic adjustments are necessary, so let me start by putting that on the table. Now I have a question, because I haven't

done a lot of work, like Judy said, with this type of price index. If using the index price versus the service price, for example, were to produce a 10 percent difference in the index for a given area, what would be the impact on the blended rate of that 10 percent?

MS. THOMAS: It depends on what the shares were. I mean, if it's 50/50 it will be 50 percent of the 10 percent.

MS. ROSENBLATT: I guess the question that's in my mind is, given all of the factors that go into the rate for a given area -- you've got the risk adjustment factor and you've got this blended, and you've actually one of three things that you're picking from. I would ask the question, what is the degree of precision necessary? We're arguing over a lot of very precise -- not arguing. We're raising questions about things that, to me might be characterized as precision that's unwarranted. And there's always cost connected with that precision in terms of doing the study. And I don't have a feel for that.

I understand your answer, but that's still not helping me make it concrete. You're saying it depends on that, and I don't know what that factor is going to be.

MS. THOMAS: It will be 50/50 for almost all plans in the future.

DR. KEMPER: But the other question is how much variation.

MS. ROSENBLATT: And then how much variation is it? If it's half --

DR. NEWHOUSE: If you got the ideal index, how much would it differ from the interim?

MS. ROSENBLATT: Right.

MS. THOMAS: I don't know.

MS. ROSENBLATT: So I guess what I'm saying is, I would find that helpful, before we get into debates of how many angels dance on the head of a pin. Because if it's a quarter -- if it's an eighth of a percent difference, it's probably not going to make all that much difference.

MR. MacBAIN: I've never heard an actuary say that.

MS. ROSENBLATT: We do that all the time. Bill said he'd never heard an actuary say that before. And I said we're constantly --

[Laughter.]

DR. NEWHOUSE: That's actuarial judgment, right?

MS. ROSENBLATT: That's exactly right. We're constantly making choices about the value of doing a study to get the precise answer versus the amount of precision that you'll end up with.

My other question, when you talked about the actuaries making adjustments for travel from rural areas into MSAs. Something that I used to worry about a lot in the calculation of the AAPCC based on fee-for-service was the snowbird issue, because I always thought that the numerator of the AAPCC calculation in a Florida county always included the fee-for-service claims of people that were there for six months, but the denominator did not include those people. I always thought that was one of the reasons the Florida counties had high costs.

So I would just raise that as an issue. Again, I don't know if it's worth the effort, but that's an issue.

I've got a deep bias against ACR as the source for anything, so I would recommend against the ACR. I really like Bill's idea of doing some staff work for us on the extremes. I think that's going to be the most helpful. Look at some of the highest cost areas, look at some of the lowest cost areas and do some modeling of what would happen.

DR. CURRERI: Sarah, I thought this was very clearly written and I thought I understood it until I got to Table 1. So I wonder if you could help me with Table 1. Looking at the example of Clark, Mississippi -- and maybe this is just an error in the table, I don't know. But I don't understand how the blended rate comes out lower than the floor rate.

MS. THOMAS: Sorry, that's clearly a typo.

DR. CURRERI: Okay. The blended rate should be somewhere between --

MS. THOMAS: I think it should be 406.61.

DR. CURRERI: Thank you.

DR. LAVE: I guess I'm going to come out on Alice's side and sort of indicate that simplicity has value associated with it. I want to point out a discussion that was held 15 years ago about whether or not only wages should be used to worry about price differences in geographic areas when clearly things other than wages vary. Heating prices
-- I mean, there are lots of things that vary in geographic areas other than wages. And there was a decision that was made, I think primarily for simplicity, that wages in fact would be used.

So I guess I have three questions about the interim wages, one of which is, it seems to me if I remember -- and Julian can answer this -- that if I sort of look at hospital costs per case and adjust for case mix, because we know that's a big one, that wages account for a lot of the other differences. So wages are really pretty powerful.

So it seems to me that they are probably pretty powerful descriptive of price differences for services, and we could test that to sort of -- for those places where in fact we have some price differences for -- we might sort of get some sense about how strong are wages. Do we really have to go beyond that? So my sense is that we probably can get a lot of the way where we want to by looking at wage differences and be fair.

So what I would ask about would be three things, one of which is, I think we can do some tests to indicate how important wage differences are in driving product prices for services, because we're talking about a service industry, and I think we can do some tests on that.

Secondly, I would worry about the shares. I guess then I'm even worried about why we -- I can understand, because of the peculiarities of the Medicare product, but it seems to me that the distribution of services in HMOs are different between hospitals and physicians than the Part A and Part B are. So I think that we should worry about what should be the appropriate weights between hospitals, physicians, and other things. And it's not clear to me that we want to take the Part A, Part B differences for HMOs because I think HMOs have a very different practice mix. I think you could probably only get some of that maybe from the ACRs. But that would be my guess if you wanted to do better.

Then thirdly, you probably do want to put administration. So you probably want to have administration, hospitals, physicians, and glunk, and have a four-part thing and see how far you get by wages. And then look at -- take the other idea and say, suppose that we could perfect this and keep the shares the same but change wages prices around, how much would that really shift what we have? Because I do think that this is an area where perfection can drive out good, and we can probably do better than we currently are.

DR. LEWERS: I wonder if Sarah could clarify for us, because I've heard a couple of references to what happens in a rural area when a patient moves into another area and where does that basically get charged. For instance, in my rural area across the Bay, the individuals there go into Baltimore and Washington. What happened before was that these all went back into the calculation of the rate on the Eastern Shore. But the BBA I think changed that and that whole area

now becomes the state, I believe. That's part of what Joe was referring to and the snowbird because we have that same problem.

I thought that I was clear on that. I thought the BBA had addressed that, and I wonder if you could clarify that for us because apparently we've got different opinions, or I'm totally off base.

MS. THOMAS: This is only with respect to the input price adjustment. It's not the base rate. The base rates are what they are. But what they've done is, because if you simply applied -- for example on the hospital side, if you simply took the hospital wage index for your county it would reflect the hospital there and it wouldn't necessarily -- that would assume that all the people in your county go to that hospital.

But if they go to Washington, since the rates were based, the original base rates are based on -- include travel patterns, it seemed to the actuary to make sense to have the input price adjuster reflect person-level health care use rather than provider location, which is why the index doesn't always look like the indices that it was supposed to -- I mean, you end up with a different set of indices to reflect travel patterns.

DR. LEWERS: What happens to Alice's snowbirds?

MS. THOMAS: I think it's all based on where people's Social Security residence is.

DR. NEWHOUSE: That's right.

MS. THOMAS: I don't know if that changes over the year. Does it?

MS. ROSENBLATT: That's exactly my concern.

MS. THOMAS: So you end up with some pretty strange values.

MS. ROSENBLATT: I don't know if there's a way to correct for that. I always worry in the work I do within a health plan to always have a match between numerator and denominator, and it sounds to me like we don't.

DR. ROWE: That's the first thing I heard this morning that I understood.

[Laughter.]

MS. ROSENBLATT: Let me make another point because I've heard some concern raised about administration. Once again, I think dealing with the administration is very complex, because if you imagine a particular health plan that's located in place A, the administration may actually be performed in B. You might have claims service people located outside of that region. You might have your executive staff located outside of that region. And it's going to be different for every single health plan.

So I think worrying about the administrative component, again, just may not be worth the trip because the variables that impact it are going to be very, very different, and you can't make the assumption that because the health plan is serving beneficiaries in one place that that's where the service is performed.

MS. NEWPORT: Let me pile in here with simplicity as the watch word. Obviously there's a lot of components to this. Is this index, it's an interim formula now. That's at the discretion of the chief actuary?

MS. THOMAS: Yes.

MS. NEWPORT: So our recommendation would then be taken under advisement, whatever it is?

MS. THOMAS: Yes.

MS. NEWPORT: Did we have, in effect, a de facto index when we were linked under the AAPCC formula? Just because that's based on --

MS. THOMAS: We didn't need one because it captured underlying price levels already.

MS. NEWPORT: I think I'm being too glib with the term delinked, but under the new formula we kind of lost whatever kind of precision there was in that?

DR. NEWHOUSE: The national component.

MS. THOMAS: You have the historic in the base. So for half of it. But the other half isn't -- is a national rate. That's where you need to adjust it.

MR. MacBAIN: I'm going to hazard asking a question I don't know the answer to. This discussion of how we weight these things that Judy was talking about earlier, I'm not real clear on and I think we need to spend some more time, whether we use the relative weights of how HMOs use services or whether we try to use something broader that is more an attempt to measure an environmental variable. I think I can make an argument that in what Joe was calling a high-powered contract you're trying to use a fixed price to encourage efficiency, and that if an HMO is able to change the mix of services and thereby improve the efficiency of the way a service is provided, it should gain from that.

DR. NEWHOUSE: This has to all be up way above the individual.

MR. MacBAIN: Yes. But still, if there's an assumption that all providers of all new plans, or all plans new or old in a given marketplace are going to behave like the efficiently managed HMO and are going to have that particular mix of services, do we preclude entry of other plans that are maybe more efficiency than the current fee-for-service mix but less efficient than the hypothetical HMO model.

Like I said, I don't know the answer to that, but I don't want to just automatically assume that we should use HMO relative weights in determining how much of this is driven by the physician wage index versus the hospital wage index versus something else.

DR. LAVE: Let me tell you why I think you want to use HMO weights as opposed to fee-for-service weights. That is, suppose that there's more variation in physician wages than there is in hospital wages, and there's a bigger weight given to hospitals than there is to physicians. Then the plan isn't going to basically be able to adjust for the higher physician prices in that area, and that's what it wants to purchase.

So it has to do with the fact that you're trying to make the prices be more reflective of the different prices that they have to pay for the services. Sometimes for some places it will work better for one thing than it will for another and the weights will advantage some places rather than another. But conceptually what you're trying to do is that you could disadvantage plans by using fee-for-service weights as opposed to the weights that are more closer to those things that they're purchasing.

MR. MacBAIN: So what you're saying is the issue is not the relative efficiency of a particular mix of services, it's trying to accurately determine what the real wage mix is in the community.

DR. NEWHOUSE: Let's be clear. If the fee-for-service plan had 50 percent of its spending on hospital services and 30 percent of its spending on doctor services, then those would be the weights on hospital and doctor services that we would now be using. But if the HMO said, reduce hospital and increase doctors, so it was using 40 percent of each, then we would move to 40/40. Now a new HMO may still well use 40/40. It's not clear to me why it would not, so it would then not matter.

DR. WILENSKY: I'd like to reiterate the point Judy made about saying, in a world that has seemed to have gotten extremely complicated, to the extent that wages are a reasonably good predictor, that we want to see how much additional we would gain if we were to broaden the other variables that we include. I think that, especially for an interim index, would make life a lot easier but maybe also be appropriate for the long term.

DR. NEWHOUSE: I agree with that.

DR. WILENSKY: Any further comments?

Sarah, you have another for the next round?

MS. THOMAS: I'm not sure what our recommendation is. A study? It sounds like that we really need to study to see how well wages match --

DR. LAVE: I guess the question that I have is the weights. The weights currently are dependent upon the Part A, Part B shift in the traditional Medicare because of the way that the payments are put together. So we may want to make a recommendation about the weights because it may well come up. And we may have to make some legal thing to do that. I don't know.

MS. THOMAS: They can change the weights. You can recommend that the weights be changed and they can implement that.

DR. LAVE: Or we could look at -- I mean, I think we should look at the differences. If we change the weights, does it make a big difference?

MS. THOMAS: Right, we could do that.

DR. NEWHOUSE: I'm kind of with Judy and Gail, that I don't think it's going to make much difference but to get to a fancier index. But one could test that in a small area by trying to do a more detailed or more accurate index for some area where you wouldn't incur a huge -- you

would try not to incur a huge cost to do the fancy index and then see how well -- what the discrepancies were.

MS. THOMAS: Yes.

DR. WILENSKY: To the extent that we could actually make the recommendation based on some preliminary analysis and then come forward to say, based on what we've done, this is what we recommend. Obviously, you could go and do a more thorough study before going ahead and adopting it if you wish. But it would be, I think, much more useful -- right now asking HCFA to do another study does not seem like a particularly useful activity.

So to the extent we can say we have done some analysis, we feel reasonably comfortable with the findings and we recommend that it would simplify the calculation of the index, that would be preferable. If attempting to verify whether the wages were a sufficiently good approximation did not leave you feeling comfortable with the results then we might be forced to say that this is the way that we think it would be preferable to go, but we have not been able to ascertain the effects.

MS. THOMAS: The only question I would pose to you is that our collecting that data, we won't be able to get that data in time to make a recommendation -- to bring an analysis to you, because we need to collect service price information and to let a contract to collect that information. So should we pass on this issue for this year until we have done the analysis to support a recommendation?

MR. GUTERMAN: I have a suggestion. It seems to me there are two levels of considerations, immediate and longer term, and there are two considerations within the immediate. On the immediate side, we've got data on hospital wages and you've got an indicator that's used to adjust for physician labor costs.

MS. THOMAS: And other things.

MR. GUTERMAN: But you've got imperfections in those, particularly in sort of what Sarah called the political considerations, how the GPCI is applied and mainly the geographic reclassification of hospitals which distorts the wage index. I think both of those are very easy to fix because they just need sort of untangling those, and the data are readily available.

So one thing that can be done is on the grounds that conceptually the inputs to producing a product that an HMO buys can represent what an efficient HMO would be expected to pay for that service. The Commission could recommend that, number one, the weights be fixed to reflect the mix of inputs that go into the products that HMOs buy. And number two, that the indexes used, even if they're based on the current data, be devised to sort of more accurately represent what the data themselves indicate rather than some of the political fixes that were put on top of those. So that's one potential level of recommendation.

Then the Commission could either say in discussion language or in the recommendation that conceptually it was in favor of reflecting more accurately, more directly, the prices that HMOs pay for the services they purchase but that in the short run the data aren't available to do that. Because off of the experience in analyzing the hospital wage index what we can tell you is that changes will matter in some cases, and they'll matter a lot in some cases. But the problem with all of those things is that you never know whether you're getting closer to the truth or further from the truth because if you knew the truth that's what you would use.

MS. THOMAS: Then we could put on the longer term agenda to make a study of that.

DR. WILENSKY: Thank you. Is there any public comment on this issue?

MR. MacBAIN: Just on Stuart's comment of removing the political fixes. I am a little nervous about that because I suspect that reality has come to reflect the political fixes, so that if we remove them we may move further away from what an HMO really faces. An HMO negotiating with a hospital is negotiating with a hospital who's being paid on the basis of the reclassification. If it is a reclassified hospital, they have to deal with that.

DR. NEWHOUSE: Only for its Medicare business.

MR. MacBAIN: Yes. But it's the mind-set. And it's Medicare business that's going to be moved out of regular Medicare into HMO Medicare and the hospital is going to be trying to maintain that same political fix.

DR. KEMPER: I think it would be possible to perhaps do a little bit of simulation about not only the effect of these changes on the existing indexes but also just maybe some sensitivity test about the question of how much difference would an ideal index make? I don't know if you can make assumptions of how much better you could do by measurement.

The other thing is I think this input price versus service price needs some more discussion before we can make a conclusion. I think of it more as an integrated product and more like a general contractor and I think that takes you in a different direction. But I believe we could have some more discussion of that another time.

DR. WILENSKY: Any further comment?

If there are any comments from the public on this issue before we proceed to the second issue this would be an appropriate time to make them.

[No response.]

DR. WILENSKY: We are going to turn to the second session, graduate medical education. As we had a number of discussions yesterday which were at a broader level of issue,

particularly as we were looking at philosophically and conceptually how to think about the prices and reimbursements that we use across different sectors, we are looking at a number of the issues in graduate medical education at a relatively broad and conceptual level today in order to try to get the commissioners ready for making more specific judgments or considering options at a later point.

There are a number of, several papers, three or four different papers that were included in the binder providing some historical information and some descriptive information about how the system now functions and how it had functioned previous to the Balanced Budget Act, as well as a couple of documents describing sources in addition to Medicare that are used to finance some portions of graduate medical education.

Stuart?

MR. GUTERMAN: Good morning. As we've mentioned several times over the last couple of days, graduate medical education is going to be on the agenda for every Commission meeting through the end of the cycle that precedes the due date of the report, which is August of 1999.

Last month we reviewed the report outline that we put together, and in this meeting we're going to follow the development of Medicare GME policy and discuss some of the basic issues that need to be addressed in the report. The next meeting we'll focus on workforce issues and begin presenting you with waves of information to hopefully help you hone your positions on these issues and develop recommendations for the August '99 report.

The purpose of this discussion is for us to together build a foundation for future discussions and for you to stake out some initial positions on these basic issues. It's our expectation that these positions will not be the final positions that the Commission takes on these

issues, but rather that they'll evolve as we continue to present you with information in future meetings from our analyses and you discuss that information and react to each other's positions on these issues.

First, let me follow through the historical development of what we refer to as Medicare GME policy. Of course, in the beginning the issue of graduate medical education costs came up in the context of a decision about what hospital costs Medicare should reimburse. At the outset, Medicare adopted what was then a state-of-the-art method of payment for insurance plans, which was to reimburse providers' costs. So the question arose, the question raised by teaching hospitals, we have these costs that are directly related to the training of residents and we'd like Medicare to consider those costs as part of the costs that the program will allow for reimbursement.

So the original issue in graduate medical education was not really how should Medicare support graduate medical education but what hospital costs should Medicare recognize for reimbursement. This initial issue sort of carries through to current Medicare GME policy and has created sort of an imbalance, because it was never developed from the outset as a decision about how to subsidize graduate medical education, rather how to consider different components of costs borne by hospitals that had to be reimbursed under the program.

The decision was made to include graduate medical education costs on the grounds -- and this is what's now referred to as direct GME costs, because the indirect costs were wrapped up in patient care costs and they were always going to be included. But the decision was made to include the direct graduate medical education costs on the grounds of quality. The statement was made in the committee report that medical education activity was associated with the quality of the facility and that Medicare wanted to encourage that. The quote was, under the

community undertakes to bear such education costs some other way, Medicare would recognize those costs.

The next development in Medicare hospital reimbursement was enacted in the Social Security amendments of 1972 and implemented in 1974, and that was the implementation of a per diem routine cost limit, the routine costs as being distinguished from hospital ancillary costs or capital costs. Hospitals were grouped on the basis of the size of the hospital, the number of beds, and the region, and there was a consideration of per capita income in the state the hospital was located in in developing these limits. A hospital would then get paid either its per day costs or the limit, whichever was less.

In developing these limits, a decision had to be made again of how to treat teaching status, and again on two levels. Here began the distinction between the direct costs and the indirect costs that were related to patient care. The decision was made -- originally there was no distinction made for teaching costs, but teaching hospitals could apply for an exception to their limits on the grounds that they bore sizeable teaching costs that would not enable them to stay below their limits. So those costs were considered in comparing the per diem cost of the hospital to the limit that applied.

In 1979, that policy was exchanged to explicitly exclude direct GME costs from the consideration of the limit, so those costs were paid on a cost basis and the rest of the routine costs of the hospital were paid according to the limits. Then in 1980, the limits themselves were adjusted to reflect higher costs at teaching hospitals. Now remember, this is per diem routine costs. So in fact, some of the difference between per case costs that we observe now at teaching hospitals and non-teaching hospitals did not affect the per diem costs.

In the Tax Equity and Fiscal Responsibility Act

of 1982, TEFRA, per case operating cost limits and rate of increase limits were implemented. This included both routine costs and ancillary costs for hospitals; still kept capital costs separate. The exclusion of direct GME costs was maintained in developing the TEFRA limits. In addition, the per case operating cost limit applied to teaching hospitals was adjusted for the level of teaching intensity at those hospitals. So again you see the formulation of the current day policies.

Now again, part of the decision there on the per case limits about how to treat direct GME costs was that if you included direct GME costs in the development of per case limits, you would then raise the average limit for hospitals across the board. So you'd not only disadvantage teaching hospitals because they would only get paid the average across all hospitals, or they would only have a limit that reflected the average cost across all hospitals, but you'd also benefit other hospitals because the GME costs would be included in. So that's part of the reason that direct GME cost was excluded, because it was seen as a cost that was not directly related to patient care.

Then in 1983, the Social Security amendments established a prospective payment per case system for operating costs, and the direct GME costs were excluded from that system and continued to be paid on a pass-through basis. That is, Medicare's share of the direct costs of graduate medical education was simply paid to the hospital on the basis of cost incurred.

In addition, the PPS payment rates were adjusted for teaching intensity directly. The initial work had found that there was a strong relationship between teaching costs and per discharge hospital operating costs. But the initial simulations found that teaching hospitals would fare poorly relatively to other hospitals using that adjustment, so Congress doubled that adjustment. So the initial adjustment was about 11.6 percent.

Here also in the development of PPS you'll see, as we'll talk about in a couple of minutes, the relationship between the indirect medical education adjustment, which is what this adjustment for teaching intensity came to be called, and the notion that teaching hospitals perform a broader social mission. Because when a disproportionate share adjustment was implemented to adjust payments for hospitals that treated a large share of poor patients in 1986, the teaching adjustment was reduced from 11.6 to 8.1 percent.

Then in 1989 when the disproportionate share adjustment was increased for a number of hospitals, the teaching adjustment was further reduced to 7.7 percent. And it stayed that way from 1989 till the implementation of the Balanced Budget Act in 1998 when the teaching adjustment was reduced to 7 percent in 1998, 6.5 in 1999, and eventually to 5.5 percent by the year 2000.

This adjustment, by the way, still exceeds the work that's being done to correlate expenses of teaching hospitals to teaching intensity. The latest work that's been done would indicate about a 4.1 percent adjustment would be the appropriate level to recognize higher costs of teaching hospitals.

Another change in the way teaching payments were made to hospitals was in the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. There were provisions in that legislation that explicitly addressed how direct GME payments were to be made. This was the first time that changes were made in that policy other than to separate it out from patient care. Per resident payment was implemented for direct GME cost based on per resident hospital costs in a base year updated by the Consumer Price Index. In addition, there were rules implemented

regarding the counting of residents for payment purposes that essentially reduced the payment that a hospital would receive for subspecialists that were training.

Now in the next overhead, the Balanced Budget Act had a number of changes in it that affected GME policy. It capped the resident count for payment purposes, and it also implemented a payment based on the average resident count over a three-year period.

The effect that had was to insulate hospitals somewhat from the effects of potentially reducing the number of residents because a three-year average would sort of soften the impact of a reduction in residents since the payment that each hospital receives depends on the count of residents that's used. There was also a provision that made incentive payments available to hospitals that promised to reduce the number of residents substantially.

In addition, the BBA allows payments to non-hospital providers for direct GME costs. We'll talk about the implications of that. The provision was intended to recognize the fact that training of residents is moving outside of the traditional hospital setting and to encourage that movement. But again, when you consider the origins of this payment amount; that is that the Medicare GME payment never was for Medicare's share of the total cost of training residents but merely for Medicare's share of the costs that hospitals bore, it's sort of taking a piece of the pie and then spreading it around in a way that differs from its origin.

The BBA also allows IME payments to hospitals for their residents while training in non-hospital settings. Again, to encourage hospitals to allow residents to train in other settings. Previous to the BBA, if a hospital allowed its residents to be trained in a setting outside of the inpatient or outpatient hospital setting it could not receive indirect medical education payments for that resident for the time that they were spending outside the hospital.

So that's the highlights and the history of Medicare GME policy. It raises a number of questions. Number one, I think the main point to take out of this is that society, Congress from the beginning on behalf of society recognized the social value of resident training and committed the Medicare program, at least until other means were found for supporting those activities, to provide its share of funding for those. But again, it wasn't a decision of how to provide support for graduate medical education. It was a decision of how to treat a component of cost that were borne by hospitals.

As you'll see as we present more information, and if you've seen it in our July data book, there's a very wide variation in the per-resident direct GME cost and payment under Medicare. That tends to be related, at least partially, to the arrangements that individual hospitals have for dealing with the cost of graduate medical education programs. In some places the faculty is paid and some places it's voluntary, and that will greatly affect the cost to the hospital of training residents. In some places more of the cost of graduate medical education programs is borne by faculty practice plans, by the medical school, by other sources than others.

That's part of the difference from hospital to hospital in what Medicare recognizes as GME costs. And that's the part, that's the piece that's being moved around right now under the BBA. That's part of, I think one of the major issues the Commission is going to have to face is how to, or whether to take a step back and consider how Medicare fits into the overall support of medical education, if at all.

There are a number of basic questions raised that we'd like the Commission to address in its discussion today that will help set the tone for future discussions on the August '99 report. One is a consideration of what society is getting for what Medicare is paying. I'll come back

to the enumeration of some of the candidates for that list. But the consideration that needs to be made is, are the amounts and distributions of these goods appropriate?

Are the amounts and distributions of the payments for these goods appropriate, since presumably they're related? One example is, if GME payments are for the training of physicians, is the distribution of physicians appropriate, both geographically and across specialties? And is the Medicare payment having an effect on that for better or for worse? That's one of the questions I think that the Commission will need to raise, to address.

Another consideration is who benefits from these payments, and do the sources match the benefits? A consideration in addressing that issue is, to what extent is there a market for these goods? Then that leads to the question of who should pay for them? Medicare currently is the only explicit nationwide payer for graduate medical education, but a number of Medicaid programs, the majority of Medicaid programs deal with this one way or another.

And private payers have recently pointed out that they pay very high rates to teaching hospitals and use that to establish a sort of implicit subsidy. There's no question that some of the surpluses that private payers have paid over time have subsidized some of the broader missions of hospitals in general and teaching hospitals in particular.

So let's go to the next overhead and try to enumerate what society is getting for what Medicare is paying. Now again, this is not what Medicare is paying for explicitly and that, again, is an issue that the Commission may want to address: how explicit should payment be for these goods?

One obviously is physician training, and there are two components of that. One is education of the next generation of physicians, and the other is the fact that residents are used in patient care, particularly in some types of hospitals and some types of places. Those

considerations certainly fall under the benefits that are derived from payment for this training activity.

Another is case mix. It's long been argued and there's supporting evidence that teaching hospitals tend to treat more complex set of cases even within DRGs. Over time that argument has been used to support the higher payments that Medicare makes to teaching hospitals. A higher level of patient care; teaching hospitals are looked at as sort of the flagships of the American health care system and many people associate teaching hospitals with higher quality of care, although that's more difficult to establish. I guess it depends on how you define it, to use a common Washington phrase these days.

There's also the role that teaching hospitals play in technological development and diffusion. That is, teaching hospitals are the places where frequently the cutting edge technology is introduced, is tried out, is perfected, and from those hospitals the technology tends to diffuse throughout the health care system. Although Medicare is prohibited from explicitly paying for clinical research, there is certainly the notion that these institutions provide the bulk of clinical research, or at least some number of them provide the bulk of clinical research and that's a social good.

Then other social missions, particularly providing care to the poor and other populations that might not otherwise have access to high quality care.

Then in my last overhead before we go into a discussion of these things, the question then arises who should pay for these goods and services? Among the things that we need to consider are Medicare's role, both as a payer for health care since many of the proposals for financing graduate medical education and the related activities and public goods have payers contributing to the pool that's available to support these activities. And as a social program,

Medicare has generally been viewed not only as a payer in a pure insurance sense but also to encourage certain things that society wants to see happen, and that certainly was reflected in the beginning in the original committee language on how to treat graduate medical education.

There are other federal programs. One of the papers in your tab describes some of the other sources of funding of graduate medical education. These federal programs play a mix of roles. One is to directly support specific activities and missions, such as the National Health Service Corps. NIH also provides a fair amount of funding for both clinical research and training. As payers for health care, Medicaid being the primary other federal payer for health care, and again as social programs since Medicaid obviously has other missions than to simply pay providers for health care.

What's the role of the private sector? That varies in different proposals for how to consider this issue. And what's the role of general tax revenues? It's frequently been argued that a lot of this function is a society-wide interest and should be funded out of general tax revenues rather than the Medicare program, and I'm sure Congress is looking to the Commission for some advice on how to deal with that.

Both as a proxy for private payers, which it has been. Most recently in the Balanced Budget Act of 1995, the graduate medical education fund that was included in that legislation that was passed by Congress and vetoed by the President included general tax revenues that could be viewed as a proxy for the contribution of other payers than Medicare and Medicaid. And also to directly support specific activities and missions. That is, if there is general funding desired to support clinical research a question might be whether that could be more appropriately directly funded rather than implicitly wrapped up.

Now what I'm going to do is ask you to go back to the previous slide and go down, sort of consider the list of what we put up there and discuss how these things play into, how you could consider what Medicare's policy should be. The two issues I'd ask you, or the two considerations I'd ask you to keep in mind are, one, from an efficiency point of view it could be argued that a number of these goals could be more efficiently acquired if they were directly funded and explicitly funded.

The counter-consideration though is that many people are nervous about unwrapping the package, because when you unwrap a package like this you make each piece of the package more vulnerable to sort of elimination. I think that's sort of the general debate about these issues, and we've seen that debate at several of the meetings of the bipartisan commission's graduate medical education work group.

So let me throw it open to your discussion.

MS. ROSENBLATT: I guess rather than addressing the specific, I have a high level question which may be very naive. But to me, since all of the components of the medical system interrelate to each other, if we were to make the assumption, let's suppose Medicare were to stop entirely GME funding, is there a way to economically model the impact of that on private payers and make assumptions about, what does that mean for hospitals, and how much do they need to increase the prices that they're negotiating with health plans and Medicare risk plans?

How do you trace through what the impact of a decision of that is on the end consumer based on the impact on all the different players in the system? Is there a way to do that at all, to sort of grasp the implications?

MR. GUTERMAN: There is a way to model it, only the assumptions would be so controversial as to overwhelm the results. I think you'd have to decide how that would flow through

the system. Certainly, if Medicare eliminated graduate medical education that would have a very severe effect on the hospitals that currently receive that funding, especially the major academic health centers. We could certainly go back and do that.

Several years ago some analysis was made of that and the results were not surprising. We found that the major teaching hospitals, which have large amounts of Medicare funding for these purposes but relatively low total margins that indicate their overall financial status, that their total margins would be substantially reduced.

MS. ROSENBLATT: But did the model take it to the next step of, the hospitals aren't going to sit there and just let their margins be reduced. They're going to pass it on to other payers. I sort of feel, in the end is it going to hit the taxpayer the same way anyway because it's all going to flow through? That's my basic question.

MR. GUTERMAN: I think there are two considerations there. One is there have been a lot of debates about cost shifting and reverse cost shifting and how that would play out and I don't think there's a consensus on how that would play out. But the other consideration is that many of the major teaching hospitals don't have a large share of private pay patients to shift back onto. So that may be good news or bad news. It may be good news for the private payers because they wouldn't be there to have to bear the burden. And it might be bad news for the academic medical centers.

MR. MacBAIN: Two things. One is, it is fair to state that the underlying public policy that's given rise to these payments is the policy of securing access for our beneficiaries to teaching hospitals and that there is not really an explicit public policy decision to subsidize graduate medical education per se?

MR. GUTERMAN: If you read the -- I haven't read all of the committee language from 1965 but I've seen excerpts in various things and there are some in the paper that is in your tab. I think that varies from time to time, but in general I think there's the notion that graduate medical education is something that is good for society and that Medicare being the available source of funding, at least temporarily, will do to support that.

MR. MacBAIN: The way we got there was because these are allowable hospital costs, not because this is a desirable public good.

DR. WILENSKY: Excuse me, I thought, based on what was put together for PPRC that the access was a more generalized access. That the rationale had been that, to the extent that there might be access problems for seniors because of inadequate supplies of physicians without Medicare support, that that was the justification for the support.

So that it wasn't specifically access to teaching hospitals because of what that gives, but that whether or not there would be an adequate supply of physicians without which seniors could not get access that they would need. That's a question that you can answer yes or no. That may be wrong, but I remember either in '96 or in '97 when PPRC was reviewing the justification, that was how they phrased the access issue.

MR. MacBAIN: I think that's an important distinction because if there has been a policy decision made that the government should be supporting this, that's very different from really saying, we sort of backed into doing this. But the policy decision was something different; simply this was one of many costs and there was no more explicit decision to subsidize graduate medical education than there was to subsidize the manufacturers of hospital beds. It simply was one of the many costs of running this particular type of hospital.

On the other hand, as you're saying and I suspect you're right, that somewhere down in the guts of this thing there was a little more than that. That there was a recognition that we really are advancing the training of medical specialists and I'd like to see a little more highlighted than we have in here because I think that leads us in a little different direction.

The second question --

DR. WILENSKY: But it was sort of this derived question.

MR. MacBAIN: It's a derivative, but I think it's still -- if it's there I think we ought to tease it out.

The other thing, and unrelated to that, but Stuart was pointing out the interrelationship between increases in DSH and decreases in indirect medical education payments and it made me wonder if in our analysis we shouldn't lump that in and look at DSH. Is DSH really another way of trying to pay for the same types of costs?

DR. WILENSKY: Stuart, did you want to respond?

MR. GUTERMAN: Yes. I think the way I would answer your question about the underlying purpose is that over the years I think a number of statements have been made about the justification for graduate medical education payments under Medicare and I think they've covered just about all of the different perspectives. So the original, the stuff I found from the 1965 report as cited in other documents was related to quality. The question was, should we allow these costs of these facilities?

And the answer was, this is an indicator of a high quality facility. It's good for the Medicare program to maintain access for its beneficiaries to these. And the broader notion that it was a societal good, not just a Medicare good and for the time being, the Medicare program should

certainly make this decision to subsidize its share of it. There was the phrase, until the community in general.

DR. CURRERI: My recollection is like Gail's. There was a considerable concern about access of the elderly to specialists. So that's why the support for graduate medical education, was to make sure there was enough specialists that the elderly would have access to them.

DR. WILENSKY: Murray reminded me of something is that part of what you may be hearing was the historical split of PPRC focusing on DME and ProPAC focusing on IME. So therefore we tended to look at these issues somewhat differently.

DR. LONG: Is there a reason we don't have a slide that says what is Medicare getting for what Medicare is paying, as opposed to what society is getting? Are those distinguishable and are we setting a tone when we only look at society here?

MR. GUTERMAN: You could look at it that way. I think the question I wanted to raise with this overhead was, what are these funds going toward? What are they supporting? What kinds of activities are they supporting? Not what Medicare is purchasing. There are sort of three levels of things. One is, what is Medicare saying that it's purchasing, which is residents because that's what it's paying for. Then there's, what does Medicare get for that money, which coincides with many of these things. And then sort of more broadly, what is society getting?

It's difficult for me to distinguish between what Medicare is getting and what society is getting in a way that made a discussion clear. But that's certainly one consideration and the question is, should Medicare be contributing to what it itself is getting or is it, as a social program, considered -- or even as a payer, given some of the suggestions that have been made about how

to fund these things. Is it Medicare's share of what society is getting or is what Medicare, the program itself is getting? Those may be different considerations.

DR. ROWE: I had a couple things I wanted to say. First, I thought that this was very well done, and I thought it was very fairly laid out, the issues that we have to address. There obviously are some overlaps in the different pieces that you sent us in terms of the content, which will be blended. But I thought that the issues, the important issues were laid out. I have a couple thoughts about ways in which we might organize it to emphasize some of the things that have been said.

One of them has to do with the comments that have been made about, is this society or is this Medicare, or are the Medicare beneficiaries benefiting? What do they get out of training pediatricians, obstetricians, et cetera, I guess would be a direct way to ask it.

DR. LAVE: They don't pay much for it, so don't worry.

[Laughter.]

DR. ROWE: And they're grandparents, so it's important. And we have a new grandparent as chair of the Commission.

But the impression I get from reading the material, and hearing my colleagues, and listening to you, Stuart, is that the language that you include that says, educational activities enhance the quality of care in institution, it's intended until the community undertakes to bear such costs in some other way that these costs will be borne by the Medicare program -- basically that language.

In doing that, whoever, the Congress -- I gather it was both the House and the Senate -- evidently said that these costs are valid costs, somebody should pay for them somewhere in the government, and until we come up with a better way we're going to park them in

the Medicare program. So it's not quite appropriate for us to say, they shouldn't be in the Medicare program until whatever it was that they were thinking of exists as another place to park it.

If that's true -- and this is not the first time you've heard this argument -- maybe what we should do is have the section highlight this a little more and say, how did this get into Medicare? And what would be the conditions, given this establishment language, what would be the conditions that would permit doing it differently, or parts of it differently or whatever? I think that I've heard two or three questions about this so far. There's a little bit of dissonance about society versus Medicare and I think we should be clear that Congress put it in here. So that's one thing.

I wanted to say a word about the additional side of this, and that is the benefit to Medicare beneficiaries, which of course, I would like to view in a net added value side. Since this establishing language there has been development of more expertise with respect to the care of older persons. We talked at the last meeting a little bit about thinking about asking the question at some point as to whether or not, since that would be, aside from this general societal benefit that's parked and we're happy, or I'm happy with it parked there, that there might be some benefit to having some incentive to establish capacity to directly benefit beneficiaries.

We might ask that question at some later point. We don't have to have the debate here.

DR. WILENSKY: I'm not --

DR. ROWE: If we want to stimulate the development of geriatric medicine in this country, that's probably good for Medicare beneficiaries. Would there be ways that we could do that within the context of the Medicare? That would be my...

For instance, if we take an absurd example which I don't think exists, but let's say there were a disease that occurred only in old people and that was common, and that there was special expertise needed with respect to its management.

DR. WILENSKY: Like Alzheimer's.

DR. ROWE: Like Alzheimer's, or Parkinson's, some rare diseases like that. I think Alzheimer's has 4 million victims now. Would it be good for Medicare beneficiaries as a whole if we developed greater expertise or manpower or something with respect to managing those problems? It might even cut costs. Who knows.

So I think that that's a question. I don't know what the answer is. But if we're going to have this question of, is Medicare benefiting versus society, maybe we should have a discussion of how that could be done or maybe shouldn't be done. So I would just add that as a question or a subquestion.

If I can go on for just another second, let me try to clarify for my colleagues how hospitals get the very, very different costs per resident, because there's a kind of an implication that it's working in the system. And I'm sure that there's some of that.

Where I work, I'm currently the CEO of two academic medical centers. One of them has a very high per-resident Medicare GME payment, one very low -- or much lower.

So when I looked at the differences, it turns out that at one of our campuses there's no director of any of the ICUs. It's voluntary; physicians volunteer their time. They come in and they sort of help run. That's their contribution as opposed to seeing patients or doing a lot of teaching. Others come in and supervise the residents and the interns, et cetera.

There are no payments from the medical center to those doctors for that. That's their contribution, so there's nothing passed through to Medicare. The training is very good, I believe, and the care is very good I believe.

At the other medical center there's $22 million of salaries paid to physicians who are directors of the ICU, directors of emergency, directors of everything. Now that's the way it evolved over 30 or 40 years, and some portion of those costs are put into the overhead of the GME program. These people spend their time supervising the residents and teaching them. And we're not starting at the creation here, we're starting where we are, and I have to reconcile this.

So these are two, I think, reasonable and valid and authentic ways to do it. The outcome is good in both cases, but they're very different cost structures. So this is how this happens. This just evolves that way. So I think that's what Stuart was referring to when he talked about the different arrangements that different hospitals have. We may want to discuss whether that's good or bad or we should change it, but at least that gives you a little information.

I had a couple very minor comments about the materials so while I have the microphone I'll tell them to you, Stuart. I thought that we might redact the statement about Congress passed it but the President vetoed it, because there might be other reasons why the President vetoed that bill. I don't think we're here -- this is, I believe, a nonpartisan group and we don't really -- it's Congress are the good guys, that President is a bad guy. I don't think we're going to -- there's not a lot of mileage to be made probably in that. Or we could take a vote --

MR. GUTERMAN: That was just intended to stress that Congress agreed on that; that it wasn't just a proposal.

DR. ROWE: No, I understand.

MR. GUTERMAN: But yes, it jumps out when you look at it.

DR. ROWE: I think we could say that a program was thoroughly developed and discussed and was included in a bill. The bill was not enacted, but the model sits there for us to revisit, or something.

DR. WILENSKY: Although it is a little -- I mean, I don't know if there is an easy way to do it. The fact, it is one thing to say that there was a bill that was put together, because the fact is there are bills that reflect opinions of one that are put together, or 10, that are put together all the time. And there is something different about any bill, either Republican or Democrat, that goes through the Congress that is not enacted because of a veto.

DR. ROWE: I think that's fine. Why don't we put in that it was developed and Chairman Wilensky wants to point out that the bill was approved by Congress and vetoed by the President.

[Laughter.]

DR. WILENSKY: That's a nonpartisan way of --

MR. GUTERMAN: At the risk of being punished for using the passive voice, we can say that Congress passed the bill but it did not become law.

[Laughter.]

DR. WILENSKY: Well crafted.

DR. ROWE: Lastly, I thought that on page 12 of the document that says, development of Medicare's GME policy, I thought this was very well and fairly done, where it talked about the financial condition of teaching hospitals, had the data for the inpatient PPS margins and the total margins, and I appreciate that. In the first paragraph of that section --

DR. LAVE: What page are you on?

DR. ROWE: I'm on page 12 of that document. While the second paragraph talks about total margins, the first one just talks about margins.

For instance, since the beginning of prospective payment, teaching hospitals PPS margins have exceeded those of other hospitals. It should say inpatient margins. Because the figure, the table actually shows that it's less. So it's a little confusing when you look at that data, then you look at the table and they're inconsistent. So that paragraph, everywhere it shows PPS it should say inpatient to tie it to the table that you show, I think. That becomes clear as you read on, but if the second paragraph gets dropped, the first one wouldn't be clear.

So those are my comments. Thanks very much.

DR. LEWERS: I agree with Jack on the points of the statements that he made regarding what Congress has said. I basically have I guess some questions and potential clarifications. By the way, Stuart, I thought the paper was an excellent summary of the history of how we got here; very educational.

I think some of what we have to decide -- and whether it's right or wrong, and I'm not sure -- is the workforce issues that you're going to present to us. I would hope that if we could get that -- as one of the papers we talked about getting early, if we could get a chance to see some of that, I think that's just --

DR. WILENSKY: I think it's intended in the next session.

DR. LEWERS: I think that is absolutely critical to some of what we're going to be doing from here on.

MR. GUTERMAN: That will be the topic at the next meeting, a major topic.

DR. LEWERS: Yes, but I want it a little earlier if I can get it than a week. We always say that.

DR. WILENSKY: Duly noted for the record.

DR. LEWERS: Nobody had said anything this meeting about it so I thought it was appropriate. But there are a couple areas I'd like to see some update on and maybe you could comment on. You mentioned the bipartisan Medicare commission, committee. I wonder if we could get an update. I know they have discussed this. I know they've made some very pointed statements. I'm not sure that means we need to agree with them or in any way impact it. But I think it might be educational, if you have that information.

The other thing is, you mentioned in the paper and today the, I'll call it an experiment, the New York experiment on restrictions, whether there's an update on is that working? What's happening? I know Jack can give us that.

DR. ROWE: Yes, I'll give you that.

DR. LEWERS: The other point, and in the paper you talk about clinical research. I think there's another area that we need to talk about and that's basic research. I didn't see anything really commenting on that at all. Because I think there is a relationship between research dollars and training, and are we now pulling -- I've heard recently in some medical school visits I've done that some of the basic scientists feel that we're basically pulling money away from that and pulling them away from their basic research and that's having an impact on the quality of physicians and even their ability to take a look at some of the research data that we have to review as physicians, and do we have the ability to do it.

That's a little too far for us to get into, but I think looking at basic research dollars may actually lead us into an area that may have something to say.

The other thing is, the NLRB decision that will be coming down soon on whether residents are students or are they employees and the impact that might have in some of this

discussion. I don't think we can do anything about it. We don't know where that's going to go, but I have a feeling that if that comes down there's going to be a lot of debate that's going to be created by that, and it's something, I think, we have to keep our fingers in as to what role that could possibly play in our debate.

But I think, as I see it, what we're doing is formulating and trying to get the background to be able to come forth with some decision to answer the questions you have here. I don't think we're ready to answer a lot of these questions at this point in time. I think that getting some of this basic information is probably more critical at this stage.

DR. WILENSKY: Ted, let me make a suggestion with regard to the bipartisan commission. As of now, the only activity relevant to that or any of the other issues is what has gone on in these work groups with no indication as to how the majority of the commission feels. But in order for them to reach their March 1st deadline, they will have to have made some decisions by January and at that point, which will be way before we need to come to any decision, we will have an opportunity to see.

I think it's of interest and instructive, but we certainly ought not to feel any compulsion to support, negate, go off in different directions. But I think it would be useful to know what they've done. But rather than try to do that based on the work group I think would be beneficial to just wait and see what they do, and that we will be able to do that in a timely way several meetings before we're in a position that we have to take a recommendation vote.

DR. LEWERS: I have no problem with that, Gail, except that if there is information coming out that would be important for us to know, even out of the work groups, I think it would be appropriate that as a commission we be given that so that we can begin to formulate our thoughts on it. I know they have not made a decision, and I know that a lot of the discussion we're hearing

are individual thoughts. But that was the point I was making. I don't disagree with you at all. We will have a shot as to what they come up with.

DR. ROWE: Let me comment on two things, if I could. One is, let me put my hat on as president of a school of medicine and say that while I'm not surprised that our basic scientist are taking advantage of access to you and your prominent position to be articulate with respect to their needs, that the NIH budget went up $2 billion a week ago.

DR. WILENSKY: 15 percent.

DR. ROWE: It's like to continue to rise. A substantial portion of that goes to basic research, though certainly not all. And I think it would really confuse the issue to start worrying about those needs, which are important aspects of things, basic research, with respect to GME. So we might make some statements with respect to the overall research enterprise and how much of it is clinical and basic. But the situation isn't desperate. It's, in my memory at least, as somebody who hasn't been around that long, never been better in terms of the prospectus I would think.

Let me talk about the New York demonstration, the waiver. There has been a fair amount of change recently with respect to that. I think it's not turning out to be as successful as people had thought it might be, although of course, it was an experiment, or is an experiment and not all experiments work. A number of major hospitals have dropped out, including Montefiore, Presbyterian, Beth Israel, St. Luke's, Roosevelt, and as of yesterday morning, the entire Rochester University consortium.

The two remaining large academic medical center consortium that are in it, there are two remaining large ones. One of them is anchored by the Mount Sinai Medical Center, the other one by the NYU Medical Center. If those two were to drop out then it would basically be left

with the Health and Hospitals Corporation in the waiver. So a lot of people are interested in what happens there.

The reasons for people not staying with it -- and I can't speak directly for them because I'm not at any of the centers that have thus far decided to drop out. But the reasons that are given are all -- they may be valid. They're also not necessarily not self-serving, but the two major ones that we hear, the first is that the Balanced Budget Act really didn't turn out to be -- this might be the only area in which the Balanced Budget Act didn't turn out to be as bad as we thought it might be for academic medical centers.

So there was a prophylactic aspect to the waiver of, are they going to kill us in the Balanced Budget Act and we need some glide path to get to some reduction without getting hurt too much. And the BBA wasn't that bad, so that's available if you don't go with the waiver.

The second is that as we do this experiment, as somebody who ran a laboratory for many years, you adjust conditions in the experiments as you move along to try to adapt to things, and we've not found our colleagues at the Health Care Financing Administration particularly flexible with respect to some of the requests that have come in to make some minor modifications. Some people think that's because they don't want the program and that this is a good way to make sure that's nobody is in it.

But anyway, that's our --

DR. CURRERI: You're really in a tactful mood today.

[Laughter.]

DR. ROWE: So these are hypotheses. So I think that by the time we meet again that there will have been some very significant decisions made with respect to that and we may have some lessons learned that we can in fact include in the report by next summer.

DR. LEWERS: They, meaning who, will make decisions? You mean HCFA, Congress?

DR. ROWE: My prediction would be that the two remaining voluntary consortia will make decisions.

DR. WILENSKY: Congress is going to make no decisions by the time we meet next. That's the only thing I feel really certain about.

DR. ROWE: But anyway, that's where we are and it's kind of interesting to see that is evolving this way, or devolving.

DR. WILENSKY: Yes, I agree.

DR. NEWHOUSE: I was going to go back to Alice's question, what would happen if the subsidies weren't there, so I'm sorry she isn't here. In a way it goes back to Stuart's initial issue of what is society getting. As Stuart had on his slide, society is getting potentially a lot of things. It's getting a different style of care. It's getting some compensation for unmeasured case mix. It's getting some clinical research.

But I think what would happen -- what effect the subsidies have had, and I would say in the form we have paid them; namely, a subsidy per resident, it would be nice if we could agree that at least one effect this has had has been to increase the number of residents and potential increase their salaries, although that's less clear in the data.

So my answer is, what would happen if the subsidies weren't there, if they just disappeared and we looked say 10 years from now as opposed to kind of short run transition hits, is that we would probably -- a reasonable speculation is that we would rerun history. That we would have fewer residents than we now have and they might make less money than they now make. And that's also quite consistent with an economic theory of this arrangement. But in any event, that

certainly is consistent with the data that we have seen over the past decade or two since these have been in place.

DR. LAVE: I just want to make a couple of broad comments since I think that's really where we are. The first one is, that I think as we think about the issue in the future I really would like us to separate the issues surrounding GME, which is the specific training of physicians and how we're going to train them, from the issues of the cost that the IME are supposed to cover. Because I think that conceptually they really are very different things and we're going to get terribly confused if we try in fact to bring them together, because I think we ought to figure out what it is that we are talking about.

The GME basically says, we are currently paying through hospital care, the cost of training physicians. I think that one of the things that is sort of important, and I think that maybe we should bring this out in the background statement a little differently, and we talked about this yesterday, is that when implicit things become explicit we think about them differently. So the GME has now become fairly explicit. We know exactly what's going on.

The second issue is that if you have a competitive market, it is very difficult to product cross-subsidized functions. So we've sort of said that, but I think that those are really two things that we ought to stress. Because the market is becoming much more competitive and it's very difficult then for people to subsidize it. We don't do it for anything else, so why should we think it would help for this?

So I think we want to take a longer look in what we're doing in developing policy is to sort of -- if the argument about the way the market is working, including the Medicaid program going into managed care, then it strikes me that we probably have no alternative but to think

differently about the way in fact that we are doing things. Maybe the status quo is not an option in the way that we are thinking about things down the line.

So those are really the two issues that I had. That is, what do we think about the status quo? Even if we like it or didn't like it, is it continuing? The second of which is to keep the difference between the GME and why it is that we pay the IME separately as we go down this path.

DR. KEMPER: I guess one of the things that I think we ought to consider here is the role of these subsidies and the role of academic medical centers and teaching hospitals in encouraging, improving quality of care. As the system moves to a more market-driven system it seems to me the incentives are, at least during the transition period, more likely to focus on the cost side. Perhaps over time as we get better information on quality and consumers get better at choosing, the competitive forces will push on the quality side. But I think at this point an awful lot is cost-driven.

It seems to me the academic medical centers play an important role in the quality of the physician workforce, and also in technological change. Not just cost-cutting technological change, but also quality-enhancing technical change. So I think that ought to be part of our discussion of these subsidies. It's not clear that these payments actually set up the right incentives for that, but withdrawing them would certainly --

DR. ROWE: I think that would be an impact. As Joe says, if they weren't there, there would be fewer residents. They would get paid less. And there are a bunch of other impacts. That might be one, and access might be one for certain -- look at the city hospitals in New York or L.A. or somewhere. There might be access for different populations.

I think one of the other requirements we should have, of course, if we do that would be that every commissioner and staff member on MedPAC, if they ever got seriously ill,

would have to be admitted to a hospital that had no residents or training programs. But presumably that wouldn't influence the quality of care so it wouldn't matter.

MR. MacBAIN: Just to follow through on this thought a little bit further of what would happen if this went away. Alice really asked two questions, of what would happen financially if the subsidies disappeared, but then what would the behavioral response of institutions be? Presumably, if there is no other support being provided for the services residents are giving to our beneficiaries, as Bill Curreri pointed out last night, they're licensed physicians. They could bill for those services.

If we want to do that analysis and do that speculation, we might include that as well, is what would happen if all of these services were compensated under Part B, both in terms of overall program costs, the effect on residency programs? Would we get unseemly battles between residents and their preceptors over who gets to bill for the patient? Those are organizations where the faculty has to live on their earnings, so that could be significant.

DR. LAVE: My understanding is that's the way the Mayo Clinic works, that they actually have a system that the residents, after they can bill, bill for their services. I might be wrong.

DR. NEWHOUSE: Not if they also take the IME from Part A.

DR. LAVE: I don't know, but Ruth Hampton at one point said the Mayo --

DR. ROWE: If I can comment, I think that would be a fundamental distortion of what residency programs are about. They are about training. And one of the objections of groups such as this, appropriately so, and the RRC and others, has always been that there's too much service being provided by residents and too little instruction and education and time to learn.

And if the incentives were all that they had to provide services that were billable it would fundamentally

-- I mean, I would not want to be a resident in that program. It's like sending somebody to college and telling them that they have to provide services they could bill for while they were in the educational environment.

DR. CURRERI: I don't think anybody was suggesting that as a solution. What we were saying is that if all support disappears that is likely what would happen.

DR. ROWE: In the unlikely and unfortunate event that this would occur, what would be the financial implications?

MR. MacBAIN: What it does is is it takes us back to Judy's point that in a competitive market-driven solution you do not have cross-subsidization. You can't expect that other good things will happen for those public goods for which there is no market, such as the time that residents need for education or the time their preceptors need for education. But it helps to focus on that issue.

DR. LAVE: I think we have to be a little careful here because you have to remember that there is training that goes on in lots of different types of organizations and they manage in fact to find a way of providing training. There is training that goes on in law firms and there is training that goes on in a whole host of organizations. So it's not as if in fact you would have no training if you got rid of this, but you would have a different form of training.

DR. ROWE: Sure. You would pay for it a different way. I pay for the training of those young lawyers when I pay my bill to that law firm for their services.

DR. LAVE: Right, but you could have taken another law firm.

DR. ROWE: I have choice. Some of the patients we're dealing with don't have choice.

DR. WILENSKY: It does raise the issue, not so much directly, of whether people are having a choice, but to the extent we want to talk about the various roles that have come up, including indigent care. Many of these discussions will require us at least indicating that we have found ourselves in a system where institutions may be providing a variety of services. If it were possible to have other sources of funding for, say, indigent care so you didn't use the academic health center or you didn't have to use the academic health center as a provider of care of last resort that this would give you options about how to fund residency or what you wanted to do that you might not be able to do until you resolve that issue.

But it does get that there are separate issues that do not have or would not have the same place in a training, education discussion in terms of indigent care. It may be that it provides some educational value as well, but that it is really there because that's how we've -- been where we've wandered and that if we were to resolve that issue that it would not be appropriately a part of this discussion.

Any other comments until we can get to more specific issues?

DR. CURRERI: I would just like to second what Ted said. I think next month is going to be a critical month because the manpower requirements, I hear so many different numbers about manpower. I'm not even sure we can get absolute numbers on what the manpower figures are and what the needs are. And if I look at other manpower studies that have been done by the federal government over the last 30 years, there's not one of them that has been anywhere close to accurate in predicting what our needs were.

But I think it is important we look at it, and I don't think we can --

DR. WILENSKY: That's why I was wondering why you were looking with such eagerness to this information. This has not had a good history.

DR. CURRERI: I understand that.

DR. LEWERS: But they're not doing the study.

DR. CURRERI: I will probably have the same questions about our look at it. But nevertheless, without that piece it's pretty hard to go much farther than we've gone today I think, because we really need to have a piece to look at at least what we think that the future needs might be.

MR. GUTERMAN: The thing I'd like to get a little more input on in terms of initial positions is the notion of sort of explicit versus -- Judy raised the issue of the direct GME versus the indirect GME. The indirect GME clearly is, both by its level and by its structure, is essentially using the teaching intensity measure as a proxy for the provision of all of these services.

The advantage you get is that there's only one determination that has to be made about the distribution of payments. The disadvantage is that the distribution of payments may not reflect the provision of the services that the program is trying to get -- either the program or society is trying to get for the payment.

The IME payments are fairly highly concentrated among teaching hospitals. I think it's the top 250 hospitals get 50 percent of the Medicare money. But even that may not reflect the concentration of some of these functions, and certainly might not reflect the distribution of some of them.

DR. LAVE: I guess my point is that conceptually we're talking about different sorts of things. In one case we are talking conceptually about this is the differences in the nature of the patient care in fact that is provided, and the types of measurements of severity and quality of the care in fact that is provided. It strikes me that that's inherently different from a policy that says how

in fact do we want to pay for the training of physicians, which is what it seems to me that the DME is.

So what I see is a patient care function; the cost of the patient's care. Now I know it's not perfect but it does seem to me that, at least in my head they are conceptually different issues. So that's why it seemed to me that it makes sense to think about them separately. We may want to pay for each of them differently than we currently do. I don't want to prejudge the answer, but it strikes me that what it is that we are talking about on those two parts is quite different.

MR. GUTERMAN: Yes, and what I was saying applies to the IME side, and sort of separating out.

DR. CURRERI: One of the things that I thought you might add to this chapter, because I don't know the answer and maybe I should know the answer. But you talk about the reduction that the BBA had for IME from 7.5 percent to 5 percent, but I don't have a good idea what that means in net dollars. Is the increase in IME from year to year, if it were 10 percent then that really isn't as much reduction as it compared if the increase in IME averages 4 percent up a year. Can you give us some idea about net dollars here?

MR. GUTERMAN: Because the indirect medical education payment is a percentage adjustment to the base PPS payment, and because the increase in those payments from year to year tends to be on the order of 3 to 4 percent under the provisions of the Balanced Budget Act, the reduction from 7.7 percent to 5.5 percent is a 29 percent reduction in the IME payments. In 1997, those payments were $4.6 billion. So it's 29 percent of $4.6 billion, or about $1.3, $1.4 billion in 1997 dollars, and that will -- the same proportional effect. So once you get to 2002 it would have the effect of, as if in 1997 there was a $1.4 billion reduction in IME payments.

DR. WILENSKY: Any other comments? Stuart, are you reasonably clear about what we're going to look for --

MR. GUTERMAN: We'll keep coming back and get closer to where we need to be.

DR. WILENSKY: We will try to make sure that the information is available as soon as possible. I do want to remind the commissioners that this is October 30th and we meet again rather soon, in about three weeks. So I think to expect a lot of advance mailing is probably unrealistic for at least November.

Let me open this to any comments that people from the public would wish to make.

MS. KELLER: I'm Karen Keller from the Greater New York Hospital Association. I just want to point out that there was a second New York innovation that occurred at the same time as the demonstration that the Commission want to think about, and that was the same year, 1997 was the year that private sector reimbursement rates to hospitals were deregulated. This was done in an environment where there was not a bed shortage -- to put it the way that I like to say it.

Concomitant with that, because of concern about the public's good mission, the state set up privately supported pools for GME financing. The pool was set up at less than 50 percent of the amount of funding that had previously been built into the regulated prices.

Two things have happened since then. The deregulation is up for renewal now. There is tremendous resistance on the part of the insurance and the employer community in continuing to support that. The pool was financed through a covered-lives tax. A lot of people have characterized this as a 13th month of premium. There is tremendous resistance.

Number two, the hospitals were supposed to have recovered the missing more than 50 percent through their negotiations with the payers. Because there is not a bed shortage at this time, the hospitals have not in fact recovered that and are under tremendous pressure.

So I just wanted to bring that up in the context of the urgency of the Medicare program, in addition to being an insurance program, being a public program that does support the public good, to bear that in mind. Hearkening back to Stu's point about the origin of Medicare supporting this in lieu of some other stable financing source.

One other point that I also want to make is with respect to what Stuart brought up again about the history of DME being excluded from the original routine cost limits because there was concern that if they were baked into the average limits that other hospitals would be taking advantage of something perhaps inappropriately. My comment relates to yesterday's conversation about the outpatient prospective payment system. There was a slide with impact on particular types of providers from the redistribution of revenue.

Obviously, we support an IME and a DSH adjustment to the outpatient PPS that came out of the regression models. But one of the things that wasn't on that slide was that hospitals with no IME and no DSH would get a 40 percent increase in their Medicare outpatient revenue as a function of having everything baked into the average rate. So I just wanted to bring that to your attention as well and consideration. Thank you.

DR. WILENSKY: Any other comments?

[No response.]

DR. WILENSKY: We thank you. This is the end of our public meeting. We will be convening in November. You may want to look at the agenda as it is finalized to see when the discussion of the outpatient PPS response to HCFA will occur.

Thank you.

[Whereupon, at 11:26 a.m., the meeting was concluded.]

[Whereupon, at 5:20 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, October 30, 1998.]